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Shaping Birth by Connecting, Protecting, Intervening:

The Nurse-Midwifery Process of Care and Evidence Based Practice

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Abstract

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By MaryJane Lewitt

The lack of evidence-based practice (EBP) in US hospitals can exacerbate poor maternal and newborn outcomes, resulting in more expensive care. Nurse-Midwifery is a growing profession, with over 11,000 practitioners, that tend to promote EBP, resulting in documented positive outcomes. Focused studies of how these practitioners use EBP in the achievement of these outcomes is severely lacking. The goal of this research was to understand how nurse-midwives practice in the current US hospital system, focusing on the processes that encourage this health provider to implement EBP. This study was framed by Bourdieu's Theory of Practice which explains that behavior results from a combination of the values and beliefs (habitus), power to act (capital), and environment (field) of the individual. The primary aim of this research was to describe the nurse-midwifery process of care occurring while this provider implements EBPs in birth management. The techniques of constructionist grounded theory were implemented with the transcripts of face to face interviews with 19 nurse-midwives working fulltime and delivering in the hospital setting, in the southeastern United States. The new theory of *Shaping Birth* describes and explains the nurse-midwifery management of labor and birth care through the processes of connecting, protecting and intervening. Implementing the techniques of situational analysis and discourse analysis resulted in the description of nurse-midwifery values, beliefs, and the environments (social, structural, and interprofessional) that influence their care within the hospital system. The contextualized theory of *Shaping Birth* was then analyzed in conjunction with descriptions of the implementation of labor induction/augmentation, medical pain relief and the decision to deliver via caesarean by the nurse-midwives to provide additional depth to the implementation of the theory with EBPs. The information gained from this study will provide the groundwork for a broader research plan aimed at minimizing the underuse, overuse, and misuse of intervention in obstetrics while increasing the use of evidenced-based maternity care. This can result in increased efficiency in maternity care with improvements in effectiveness, safety, quality and team work.

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Finally, **to all my colleagues in obstetrics and to all patients of midwifery**: This research is for you. Through the lens of *Shaping Birth*, I hope you find insights and new ways of continuously striving to achieve the highest quality and safest care possible. Our future is in your hands.

Table of Contents: **Page:**

Chapter 1: Aims and theoretical framework 1
Introduction 1
Pregnancy and birth is expensive and potentially risky 1
EBPs can decrease cost and increase positive outcomes. 2
Aims 3
Theoretical framework 3
Social Constructionism 3
Bourdieu's Theory of Practice 5

Chapter 2: Background, literature review, and significance 8
Implementation of EBP improves Quality and Safety 8
The quality and safety of health care in the US needs improving 8
Overuse, underuse, and misuse of interventions 11
Most Births occur to *Healthy* Women Undergoing a *Healthy* Process 13
How providers define health may affect use of evidence 13
Biomedical theory views health as achievable only through intervention 14
Salutogenic theory of health views health as being able to realize goals 20
Integration of Salutogenesis and nurse-midwifery philosophy 23
Nurse-midwifery has strong ties to the implementation of EBP 25
Why Study Nurse-Midwives? 26
Nurse-midwifery is uniquely situated 27
Low rates of morbidity and mortality and no known adverse effects 28
The process of nurse-midwifery is unknown 30
Significance 32

Chapter 3: Research design and methods 35
Methodologies 35
Constructionist grounded theory 35
Situational analysis 36
Discourse analysis 37
Study sample 39
Participant enrollment 40
Consent process 41
Interview procedures 42
Description of participants 47
Data analysis 48
Research Integrity, Reflexivity and Difficulties 57
Theoretical Sensitivity 63
Difficulties 64
Limitations 66

Credibility 68

Chapter 4: Process and Outcomes 72
Overview of *Shaping birth*: The nurse-midwifery process of care 72
Cultural analysis of the work world of nurse-midwives 73
Habitus of nurse-midwives 73
History of nurse-midwifery is embedded in a nurse-midwife's habitus 73
Values and beliefs of practicing nurse-midwives 78
Inner Beliefs 79
Interactive Beliefs 85
Process Focused Beliefs 91
Capital of nurse-midwives 94
Interactions with physicians and nurses 95
Interactions with individuals who influence birth management 102
Interactions with clients/ patients 105
Field of nurse-midwifery care 106
Exposing the field via situational analysis 106
Collective actors and connections affecting nurse-midwifery care 112
Shaping birth by connecting, protecting, and intervening 119
Emergence and evolution of the theory of *Shaping Birth* 120
Shaping Birth: The nurse-midwife process of care 126
Connecting 128
Protecting 134
Intervening 138
The goal: Achieving a healthy, vaginal birth 143
EBPs and Shaping Birth: The nurse-midwifery process of care 150
Usage of oxytocin for induction or augmentation by nurse-midwives 154
Usage of pain relief in labor by nurse-midwives 157
Cesarean usage by nurse-midwives 159

Chapter 5: Discussion 163
Implementation of *Shaping Birth* through embodying leadership 166
Significance of the implementation of *Shaping Birth* 172
Partial implementation of *Shaping Birth* 176
Implementation of *Shaping Birth* supports EBP in birth 177
Future steps 178

Tables

Table 1: Study Participants 41
Table 2: Statistical Descriptions of Participants 46
Table 3: Categorical Descriptions of Participants 47
Table 4: Exposing the Analysis 51
Table 5: Selected excerpts from my pre-understanding of nurse-midwifery practice 63

Figures

Figure 1: Interpretation of Bourdieu's Theory of Practice 7
Figure 2: Health is the ability to realize goals. 21
Figure 3: Image of actual messy working map 57
Figure 4: Values and beliefs of currently practicing nurse-midwives 78
Figure 5: Inner values and beliefs 79
Figure 6: Interactive values and beliefs 85
Figure 7: Process focused values and beliefs 91
Figure 8: The Three Worlds of Medicine, Nursing, and Nurse-Midwifery intersect to form the Central Domain where Patient Care is provided via Teamwork 97
Figure 9: Messy working map of CNM caring for Patient in labor 107
Figure 10: Ordered Situational Map of CNM caring for patient in labor 108
Figure 11: Relational connections around personal factors affecting CNM care 111
Figure 12: Initial model of Nurse-Midwifery Process 120
Figure 13: Intermediate Model of Nurse-Midwifery Process 122
Figure 14: Shaping Birth: The Nurse-Midwifery Process of Care 126
Figure 15: Expanded version of Shaping Birth 127
Figure 16: Connecting: The first step in Shaping Birth 128
Figure 17: Protecting: The second step in Shaping Birth 134
Figure 18: Intervening: The third step in Shaping Birth 138
Figure 19: Achieving healthy vaginal delivery: The goals of Shaping Birth 143

Appendix

Appendix 1: IRB Approval 182
Appendix 2: ACNM Approval to Solicit Membership for Research Participation 183
Appendix 3: Demographic and Participant Information Form 184
Appendix 4: Participant Screening Form 185
Appendix 5: IRB approved consent 186
Appendix 6: Interview guide 189
Appendix 7: Additional questions 192
Appendix 8: Codes- situational analysis 193
Appendix 9: Codes- values and beliefs 198

Appendix 10: Codes- constructionist grounded theory 202

References 206

Chapter 1- Aims and Theoretical Framework

Introduction

Pregnancy and birth is expensive and potentially risky.

Although in many respects childbirth is considered a normal and healthy process, it still contains risk, and represents a significant portion of the U.S. health care system costs. Pregnancy and birth is the single most expensive aggregate condition billed to Medicaid and private insurance (Andrews, 2008), with over 4 million hospitalizations (KaiserNetwork.org, 2007) that total over $86 billion per year in costs to the US health care system. Childbirth practices that are not grounded in research based evidence have increased dramatically over the past 40 years resulting in a 50% increase in the relative cost of birth (S. Tracy & Tracy, 2003). National cesarean rates have increased six-fold over the past four decades to almost 1 in 3 live births (32.8%), (American College of Nurse-Midwives, 2008; J. Martin et al., 2007; J. Martin et al., 2012; Viswanathan et al., March, 2006) and are becoming the most common operating room procedure in the United States (Levit, Wier, Stranges, Ryan, & Elixhauser, 2009). This increased rate of intervention during labor and birth has not improved maternal or infant morbidity/mortality (World Health Organization, 1997) and, as a result, the US currently ranks 29th out of 37 developed nations for infant mortality (MacDorman & Mathews, 2008) and 27th out of 41 for maternal outcomes (Save the Children, 2008). The lack of evidence-based practice (EBP) in US hospitals, where 98.8% of births take place (J. Martin et al., 2012), can exacerbate poor maternal and newborn outcomes, resulting in more expensive care.

EBPs can decrease costs and increase positive outcomes.

Multiple health organizations have called for the use of EBP during the birth process in order to ensure quality, efficiency, and safety (Institute of Medicine, 2001; U.S. Department of Health and Human Services; World Health Organization, 1997). The implementation of EBP is a process influenced by many factors, as it requires the integration of the best evidence with clinical expertise and patient choice (Closs & Cheater, 1999; Sacket, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). Nurse-Midwifery is a growing profession, with over 11,000 practitioners, that tend to promote EBP, resulting in documented positive outcomes (Hatem, Sandall, Devane, Soltani, & Gates, 2008; MacDorman & Singh, 1998). Focused studies of how these practitioners use EBP in the achievement of these outcomes is severely lacking. Nurse-midwives have historically concentrated on individualizing care, and supporting normal processes in birth, specifically working with populations experiencing high rates of health disparities. (Banks, 1999; Cragin, 2004; Rooks, 1997; Rosenblatt, 1997; H Varney, Kriebs, & Gegor, 2004). A description of how nurse-midwives use EBP in the hospital setting would facilitate the discovery of various approaches to expand use of evidence-based maternity care to achieve optimal birth outcomes and potentially lower the costs of healthcare.

The goal of this study is to understand how nurse-midwives practice in the current US hospital system, focusing on the processes that encourage this health provider cadre to implement EBP. To fulfill this goal, I generated a theory that illustrates how nurse-midwives' values, beliefs and environments (social, structural, and interprofessional) influence their care within the hospital system. This exploratory study used constructionist grounded theory to describe current nurse-midwifery practice in the

hospital setting and illuminate the factors influencing that care. The information gained from this study will provide the groundwork for a broader research plan aimed at minimizing the misuse of intervention in obstetrics while increasing the use of evidenced-based maternity care. This can result in increased efficiency in maternity care with improvements in effectiveness, safety, and quality.

Aims

The aims of this study are to:

1. Describe internal beliefs and values that typically frame current nurse-midwifery practice.
2. Describe the social, structural, and interprofessional environments that influence current nurse-midwifery practice.
3. Propose a new theory explaining the current processes of nurse-midwifery practice in the hospital setting, focused on actions resulting in the use of evidence-based maternity care.

Theoretical Framework

In contextualizing this research, I have used social constructionism and specifically Bourdieu's Theory of Practice.

Social Constructionism.

Social constructionism is a philosophical position in which people's worldviews are created by individual interactions in everyday life, and therefore research findings are constructed jointly, and socially, between the researcher and their participants. Social constructionism started being used by nurses in the 1990's and 2000's, as nursing scholars began to implement research methodologies from the areas of discourse analysis,

ethnomethodology, and anthropology (Latimer, 2008). These techniques have allowed researchers to reveal socially constructed views of illness and to describe the practice of nursing by studying how patients and nurses interact: what they say, do and write. Through observations, and interactions, the researcher engages with philosophy and theory in a dynamic, socially constructed process that reveals how patients and providers approach health care (Allen, 2004; Latimer, 2008). The primary idea of constructionism is reality/truth is constructed by each of us through our interactions with the elements of everyday life (Gubrium & Holstein, 2008). Constructionist research recognizes that the process of research inherently influences the outcomes of the research. When a scientist asks a question, he or she has the potential for influencing the answer through the way the question is asked, through body language and through the intonations of voice. Even the environment in which the interview takes place has a potential for influencing the answers the researcher will receive. The process of preparing for, scheduling, setting up and implementing an interview influences the outcome of the research. During the interview process, participant and interviewer work both together to analyze the subject matter. The participant does this by carefully thinking and answering the questions, while the researcher accomplishes this through a process of exploring and probing. In this manner, the outcome is constructed jointly and socially- through discussion and interaction by the researcher and the participant.

The theoretical lens that the researcher uses to guide their study can also be a significant influence, as it guides the formation of the research question, the data collection, the data analysis and the interpretation. Practice theory, as a general theoretical framework, will guide this study. Emerging in the late 1970’s and early

1980's, practice theory replaced the view that all human behaviors result from outside social and cultural forces that constrain behavior (Ortner, 2006). Practice theory, instead, proposed a relationship between the constraints (or enabling) capacities of culture and society and the "practices" of humans (Ortner, 2006). Practice theory proposes that objective understanding of a situation does not reveal the essence of event. Instead this can only be perceived from gaining an understanding of the individual's view, as individual actors may define the situation differently than observers, based upon their own history and knowledge of the environment. Uncovering and studying the conscious and unconscious influences of outside power and structures upon the actions of individuals is a focus of practice theory and one of the main objectives of this research.

Bourdieu's Theory of Practice.

As a specific example of social constructionism and practice theory, the Theory of Practice (Bourdieu, 1977, 1990) illuminates how values, attitudes, beliefs, behavioral control, and the environment influence the desired behavior. Bourdieu's Theory of Practice illuminates how personal characteristics and the broader social environment interact to influence behavior, placing individuals within the context of the social world so that an understanding of both individual and group behavior might be achieved. The Theory of Practice was proposed by Pierre Bourdieu in the late 1970's as a way of synthesizing the epistemologies of both objective structuralism and subjective existentialism. This theory states that human actions are formulated from motives, beliefs, rules and values. People interpret stimuli from the social environment and these interpretations shape their actions and behaviors (Sallaz & Zavisca, 2007). Bourdieu's theory consists of the interaction of three major components: field, capital and habitus.

The field is the frame of reference and represents the environment in which the behavior takes place. The field consists of hierarchical, legislative and organizational structures that reflect the dynamic interactions and relationships between individuals and societal structures. In the context of this research, this would include collaborating relationships, hospitals, the payer industry, or the state and national healthcare system. Capital represents the power an individual possesses which is utilized or exchanged to improve their hierarchical position within the field. Capital is also inherent in the interactions between individuals and is represented in the symbolic or cultural power that some people possess over others. Those individuals with more control over their behavior possess greater capital and more hierarchical power within social interactions. Habitus is the manifestation of the embodied reality of an individual, resulting from the compilation of norms, attitudes, beliefs, traditions, customs, history and principles. It is a combination of the objective influences of culture and the subjective influences which exist in the mind of the individual. The individual, as part of a culture, has their own set of 'dispositions' which they know how to follow (Bourdieu, 1977, 1990). Similar to Noam Chomsky's notion of linguistic competence, that a "native" speaker has an intuitive model in their mind about how to speak (Duranti, 2001), habitus is an internal model which shapes behavior. *The Theory of Practice aligns the embodied reality of the individual (habitus) with their perceived power (capital) which results in practice behaviors within a specific environment (field).* By analyzing an assemblage of many different individuals' behaviors, patterns of behavior can be identified reflecting current practice behavior.

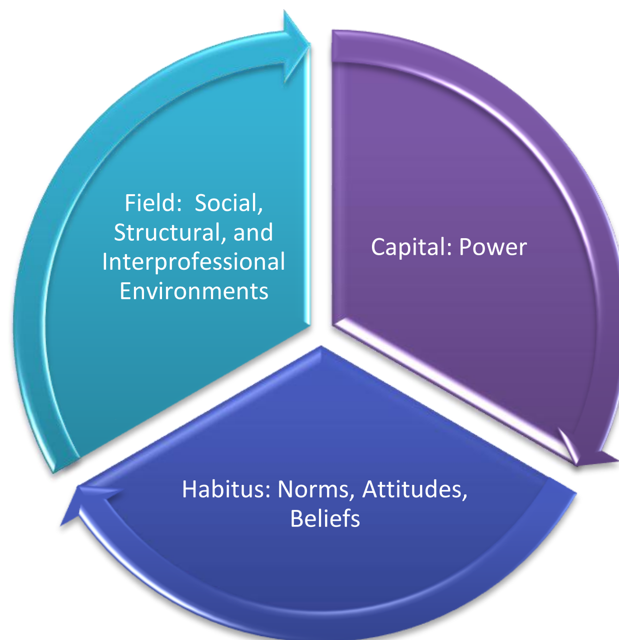


Figure 1: Interpretation of Bourdieu's Theory of Practice

Using the above theoretical frameworks, this study will attempt to reveal nurse-midwifery practice as constructed from the views of nurse-midwives currently practicing in the hospital setting and inclusive of the various factors that influence their behavior and their implementation of EBP. Although nurse-midwifery is not a profession of all women, for clarity sake, I will refer to the members of this profession with a female pronoun. Names mentioned with textual quotes were assigned by the researcher and are not associated with participants.

Chapter 2- Background and Significance

Implementation of EBP improves Quality and Safety

The quality and safety of health care in the US needs improving.

Health care quality and safety has much room for improvement in the United States (Institute of Medicine, 1999). Three major reports in the past 15 years have shed light on this significant problem (Chassin & Galvin, 1998; Institute of Medicine, 2001; Kohn, Corrigan, & Donaldson, 2000). Many issues such as underuse, overuse, misuse of health care services and resources (Chassin & Galvin, 1998; Shortell, Bennett, & Byck, 1998), and the gap between optimal health care delivery and our current system are currently the target of research and reform. At the beginning of the 21st century, *To Err is Human* (Kohn et al., 2000) captured the attention of many significant stakeholders in health care while shining light on the issue that patient safety and medical errors are a significant driver of poor quality in the U.S. health care system. Shortly thereafter *Crossing the Quality Chasm* (Institute of Medicine, 2001) was presented by the Institute of Medicine (IOM) as a framework for redesigning our health care system in a manner that is consistent with six specific aims for improvement (safe, effective, efficient, timely, patient centered, equitable), acknowledging that each one affects the other. Health care providers all strive to improve the health, well being, and quality of life for the patients they serve.

These improvement goals are being set for a health care system which is in essence “an ever-growing, and now gigantic, cottage industry” (Hagland, 2009, p. 140) and is thus lacking the structure to standardize processes, institute quality control, and eliminate waste. In its origin, the industry was paid by insurance groups that were not the

consumers of their services. The individuals who direct how resources are used are often not the employees of hospitals or health care organizations that provide care. This has resulted in a significant misalignment of goals and incentives within the health care system and has led to the identification of many issues for reform. Right now, the health care industry has numerous plans for implementing improvements. However, the biggest challenge health care providers face is sustaining this change (Hagland, 2009).

The quality of health care in the United States is improving; however the rate of that progress is sluggish. Quality improvement is composed of six dimensions: care characterized as safe, effective, efficient, timely, patient centered, and equitable (Berwick, 2002; Institute of Medicine, 2001). Since 2003, the Agency for Health Care Improvement and Quality, in conjunction with the Department of Health and Human Services, has reported yearly on the current status of health care quality. The National Healthcare Quality Report (NHRQ) focuses on the four quality areas of 1.) effectiveness, 2.) patient safety, 3.) timeliness and 4.) patient centeredness across 220 measures (Agency for Healthcare Research and Quality & U.S. Department of Health and Human Services, 2008). The median rate of change for all the measures under observation was 1.4% between 2003 and 2008, with 132 out of the 190 measures showing some improvement. Our health care system, while it is experiencing modest improvement, is still not achieving the substantial improvements required to close the “quality chasm” that exists. Despite a desire to focus on improving preventive and chronic care services, the United States Health Care System functions at its best when providing care in response to acute conditions. Quality improvement is occurring more rapidly in hospital settings (almost 3%) while ambulatory settings are experiencing lower rates of positive change

(close to 1%). Overall trends in patient safety, on the other hand, are showing declines of almost 1%. In terms of clinical conditions, respiratory diseases are exhibiting the highest improvements (4.3%), followed by heart disease (2.6%), cancer (1.9%), maternal and child health (1.3%) and with diabetes showing almost no improvement (0.1%) (Agency for Healthcare Research and Quality & U.S. Department of Health and Human Services, 2008).

Critical to the development of measures to evaluate health care quality is a foundation on evidence-based practice (EBP) (Agency for Healthcare Research and Quality & U.S. Department of Health and Human Services, 2008). EBP is a process that integrates the conscientious use of current best evidence with clinical expertise and patient preferences in making clinical decisions to achieve optimal patient outcomes (Closs & Cheater, 1999; Institute of Medicine, 2001; Sacket et al., 1996). Best evidence refers to the most rigorous and relevant clinical evidence and research that supports a selected intervention. Clinical expertise involves the integration of knowledge and judgment gained through practice over time which allows the practitioner to integrate best evidence with patient preferences in making informed clinical decisions. Patient preferences are also integral to the implementation of EBP (Closs & Cheater, 1999; Institute of Medicine, 2001; Sacket et al., 1996). Evidence-based maternity care involves the implementation of EBP in obstetrics and is characterized by the provision of effective care with the least harm (Sakala, Corry, Childbirth Connection, Reforming States Group, & Milbank Memorial Fund, 2008).

Overuse, underuse, and misuse of interventions.

Interventions, when used according to the best evidence and integrated with clinical expertise and patient preferences, are part of a safe, effective provision of obstetric health care. However, when interventions are overused, underused, or misused, the potential for significant harm, decreased quality and safety, and increasing costs to the health care system exist. Overuse of interventions is the provision of unnecessary care without specific medical indication or when care is given during a situation where the potential for harm outweighs the possible benefits of care (Chassin & Galvin, 1998; National Quality Forum, June, 2009; Orszag, 2008). Misuse of interventions involves the provision of appropriate care with a subsequent preventable complication precluding the patient from receiving the full potential benefit (Chassin & Galvin, 1998; Orszag, 2008). Underuse of interventions involves the failure to use a service that would likely benefit the patient (Chassin & Galvin, 1998; Orszag, 2008). Overuse, underuse and misuse are all quality and safety issues that can be addressed through use of EBP.

The misappropriate uses of health care resources, including hospital staff, equipment, supplies, and space, without concomitant benefits to patients, escalates the cost of health care in the US (S. Tracy & Tracy, 2003). For instance, the aggregate costs of hospitalizations for birth increased by $7 billion, in 2006, to total over $86 billion (Andrews, 2008) resulting in an average vaginal delivery cost of $8,300 and a cesarean birth cost of $11,500 (Viswanathan et al., March, 2006). Over half of these costs are due to an escalating cascade of non-evidenced based interventions in birth (S. Tracy & Tracy, 2003), which includes a six-fold increase in the national cesarean rate and a 50% increase in induction of labor rates over the past two decades (J. Martin et al., 2007).

Although there is an official push to include more EBP in obstetric practice, the current cultural paradigm does not always encourage such practice, often resulting in the overuse and misuse of multiple interventions during birth. This paradigm is a result of historical precedent, cultural and social expectations, hegemonic power structures, technological advances, and a litigious society, all working together to suggest to both provider and patient that the “best” delivery is the one in which the highest level of interventions are used (Downie & Macnaughten, 2000; Herman & Chomsky, 1988). The use of many of these high level interventions often takes place during normal or routine situations where their implementation is not supported by evidence, medical justification, or improved outcome. This practice environment prompts complications in birth for both the mother and child, including fever, infection, injury and increased blood loss, and increasing rates of postpartum depression and increasing rates of cesarean section (World Health Organization, 1997; World Health Organization Department of Making Pregnancy Safer, 2007). In response to this change in paradigm, many organizations including the National Priorities Partnership (National Priorities Partnership, 2008), National Quality Forum (National Quality Forum, June, 2009), World Health Organization (WHO) (World Health Organization, 1997; World Health Organization Department of Making Pregnancy Safer, 2007), Institute of Medicine (Institute of Medicine, 2001), the Partnership for Safe Motherhood and Newborn Health (The Partnership for Maternal Newborn and Child Health, 2005), Save the Children Foundation (Save the Children, 2008), and the Coalition for Improving Maternity Services (Coalition for Improving Maternity Services, 1996) have all prioritized the use of EBP during labor and birth.

Most Births occur to Healthy Women Undergoing a Healthy Process

Although not without risk, most births occur to healthy women undergoing a healthy process. The primary goal of achieving a state of health is the basis for all action and intervention in health care. However, what does health mean in this context? How does one achieve a healthy birth? The definition of *health* will depend upon the theoretical and philosophical viewpoint of each provider of care. Physicians, nurses, and nurse-midwives all may use the same word, but to each professional, *health* may mean something different. How providers define health may affect their choice to implement EBP. With over 99% of all births in the United States uncomplicated by severe maternal morbidity (Callaghan, Creanga, & Kuklina, 2012) and 57% of all childbearing women giving birth without concurrent morbidity (Danel, Berg, Johnson, & Atrash, 2003), it could be said that most births occur to *healthy* women undergoing a *healthy* process. Yet the rate of medical intervention in birth is very high with less than 2% of women experiencing a birth in which evidenced based practices to promote, protect and support normal birth were instituted (Declercq, Sakala, Corry, & Applebaum, 2006, 2007).

How providers define health may affect use of evidence.

How providers define health will affect the choice to implement EBP. If intervention and EBP are used to support and maintain health, then the transition from health to a state without health must be determined by each provider. To gain an understanding of how a nurse-midwife approaches birth management, an understanding of what health means to nurse-midwives must be clarified. As a way to understand the nuances between the professional differences in defining the term health, I first undertake

an analysis of the term focusing on the definition of health by medicine and nurse-midwifery and then how it is reflected in birth management.

In the United States, culturally accepted definitions of health include a belief that health is something that care be definitively diagnosed. Historically, the body has been understood to work as a machine. It is healthy when the body is in homeostasis and lacks health when injury or illness affects one or more systems. Health is defined as an absolute state, that can be either present or absent but not both: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(World Health Organization, 1948). This certainty that characterizes health affects the approach to action to achieve of this state of being.

Two conceptual approaches to health dominate the current philosophy. The more prevalent theoretical approach is the biomedical theory of health. The other is a constructivist theory of health, specifically the theory of salutogenesis. This theory represents a holistic and normative viewpoint, which is in greater alignment with the beliefs of the profession of nurse-midwifery.

Biomedical theory views health as achievable only through intervention.

The biomedical or biostatistical theory (in some circles, these theories are categorized as part of objectivism or naturalism) (D. Murphy, 2008) views 'health' and 'disease' as biological definitions, just like the definitions of 'uterus' or 'birth'. Possessing biological definitions, these words are inherently value-neutral, despite our personal desires to prefer one over the other. Boorse (1975, 1977) describes health as the state when all tissues and organs are functioning homostatisically in accordance with the maintenance and renewal of life. Health is not personified in this definition, it is

descriptive. Health is evocative of a state when the individual is functioning in perfect working condition. Health is contrasted to the states of disease and illness. Disease is the impairment of our normal functional ability, which is determined statistically over our lifespan, or a limitation caused by environmental agents. Illness is the experience of disease that involves a state of incapacity combined with undesirability, entitlement to special treatment, and the ability to use as a valid exception for behavior outside the routine. These definitions characterize medical terminology as value-neutral terms, and include descriptions of human physiology as, metaphorically speaking, industrial and machine-based.

Disease alters the work of the machine and subverts the natural process. It changes the actions of the individual. Disease is personified and provided with agentive behaviors aimed at removing the condition of health from the individual. The medical-machine voice is activated by this definition. The intertextuality of the multiple voices of body as machine, medicine as certainty and the individual as non-agentive are all present in this definition. Health is something that exists and disease is a process that changes health and is outside of individual control.

Recently, the biomedical theory has been undergoing competition from the actuarial model of disease (Green, 2007). The actuarial model correlates the presence of elevated health risk as equivalent to disease regardless of additional overt symptoms or an injurious pathological process. Life is viewed as a problem, as risk is everywhere. The body is seen as an imperfect machine which can only achieve health with significant intervention.

> *Health is the success of external agents (treatments) over nature in temporarily eliminating disease or other pathological conditions from the body. Nevertheless, the risk, whether high or low, of disease or death remains. Disease results from the failure of the external agents and , therefore, the failure of the individual and the medical care system. The ultimate failure of the individual and the physician is death: the greatest enemy, against which an all-out struggle must be waged.* (Wagner, 1994, p. 28)

This definition of health further supports the determinism that individuals lack the agency to affect their own health. Health is either present or not present. This definition adds an outside actor to the process. This actor is that of the physician, who is characterized as a warrior in the battle against the disease, but one who may not always have agentive power to win the war. The war metaphor can also perceive the body to be a battlefield, with the physician invoking the voice of the military to war against the enemy, disease, which will eventually win regardless of all treatments. Disease is personified as the enemy and treatments are seen as military incursions using weapons of war. The war is characterized as unwinnable: “the risk, whether high or low, of disease or death remains.” The fact that the ending of the war is defined by death brings a sense of helplessness and hopelessness to this war. Health is further quantified as a transitory condition- filling in the gaps between the incursions of natural forces of aging which are characterized as the enemy. Health is also separated from nature, in a manner that aligns nature with pathological conditions. The achievement of health is a momentary condition that occurs as a result of medicine’s successful battles. The medical care system and

physicians are characterized as our best fighters but they are not always able to conquer the enemy. Their agency is incomplete, they can act to fight and may win individual battles, yet they will always lose the war by death. The battles make take place in specific areas of the body, but in time the entire battlefield will be lost.

> "Obstetrics is an art and science combined, and its practitioners must be concerned simultaneously with the lives of at least two intricately interwoven patients- the mother and her fetus(es). Because of the expectation of life with continued good health for these two (or more) persons typically exceed 120 years, it is apparent that the responsibility of the obstetrician is enormous, but then so are the humanitarian rewards of successful pregnancy management" (F. G. Cunningham, MacDonald, P.C., Leveno, K.J., Gant, N.F., Gilstrap, L.C., 1993, p. ix).

This excerpt from *Williams Obstetrics*, the leading primary text for the medical practice of obstetrics and gynecology, is representative of the beliefs and practice of physicians in the care of women and their infants. This text is read and engaged by medical students throughout their training and further used by residents and interns who choose to specialize in this area (F. G. Cunningham, MacDonald, P.C., Leveno, K.J., Gant, N.F., Gilstrap, L.C., 1993). The use of specific words and word types within this first paragraph, taken from the preface to the text, lays the groundwork for an understanding of the beliefs and views of the practitioners of this profession. Viewed as both art and science, medical practitioners are actualized as acquiring mastery in both realms, and this mastery leads to a position of enormous responsibility resulting in

rewards that are described as humanitarian. The juxtaposition, between the 'significant responsibility' taken on personally by the obstetrician and their rewards, are not characterized as benefiting society but as benefiting the obstetrician, illustrated through the relationship between these two clauses (Fairclough, 2003). This relationship between the clauses sets up a comparison resulting in an understanding of equivalence in terms of an understood personal reward and benefit relationship. This focus on personal roles and rewards highlights a potential motivation that characterizes the medical profession. In addition, the patients of the obstetrician are not discussed directly, but rather very generally, and lay terms such as 'infant' or 'baby' are replaced by the medical/scientific term 'fetus', resulting in the depersonalization of the patient. Patient participation in the process is not mentioned, but rather the actions and agency of the physician are highlighted. 'Successful pregnancy management' is what directly results in the potential reward allocation back to the provider. The phrase 'successful pregnancy management' nominalizes the process of care, further generalizing and abstracting it, but also effectively hiding patient involvement, agency, free will, and responsibility as it impacts outcomes of care (Fairclough, 2003).

The practice of obstetrics contextualizes reproduction in terms of health and well-being for society (F. G. Cunningham, MacDonald, P.C., Leveno, K.J., Gant, N.F., Gilstrap, L.C., 1993, p. 1), despite the contradiction in reward allotment. As a profession now responsible for all of society, obstetrics has set itself up as the authority figure responsible for and thus capable of defining appropriate societal outcomes. This medical hierarchy established a hegemonic power structure through the use of their ideological statements (Fairclough, 2003). These definitions of health and well-being are

intertextualized through implicit assumptions as those congruent with the dominant beliefs of health within the medical practice; specifically the various biomedical theories of health.

According to Cunningham (1993, p. 1), outcomes of care do not occur spontaneously, but only through the use of technological intervention on the part of the physician. This intervention is needed to prevent the death and injury of women who undergo reproductive processes. This intertextualizes our previous discussion of health as a transitive condition that only results out of direct medical intervention: intervention characterized as a military incursion against 'normal forces' that can result in pathological injuries leading to death (Wagner, 1994, p. 28). The intertextuality inherent in the provision of care by obstetricians illustrates the medical habitus and medical worldview. The habitus is a "set of dispositions which incline agents to act and react in certain ways" and it "also provides individuals with a sense of how to act and respond in the course of their daily lives" (Bourdieu, 1991, pp. 12-13). Intervention is a necessary and an important strategy to be used in the management of all reproductive processes, as these processes all carry the risk of injury and death. All other normal processes are also inherently risky, as they also can cause injury and death. Based upon these texts, obstetricians can be interpreted as viewing their practice as one that is focused on the reproductive management of society; individual accommodations are seen as counter-productive to the process of improving the reproductive outcomes of society. These passages also reflect a larger hegemonic power structure operating within provision of health care. A definitive hierarchy exists and the profession of obstetrics has positioned itself to be at the top of this hierarchy. The concentration on abstract individuals and

society in general, sheds light on the aspirations of this profession. With the use of terminologies that naturalize the realms of expertise and control while exhibiting dominance over society at large, the profession has set up a structure that supports their ultimate authority over medical issues affecting reproduction.

Salutogenic Theory of Health views health as goal realization.

According to constructivists or normatist philosophers, the definition of health, in contrast to the biomedical theory, is inherently value laden: being healthy is good. Nordenfelt's welfare theory of health (Nordenfelt, 2001), states that a person is considered healthy if they are in a physical and mental state consistent with the ability to realize all their vital goals. Health involves the whole person, not just individual parts of the body, in contrast to Boorse's theory (Nordenfelt, 2001, p. 65). The whole person is either healthy or ill, not just their lungs, liver, or heart. If an illness is in the lungs, such as pneumonia, then the entire person is sick, not just exclusively their lungs. If their ability to realize their goals is diminished, then they would be considered ill. The processes that diminish a person's ability to realize their goals and thus causing harm are called diseases. Constructivists maintain that there is no one singular, natural, or objectively definable set of human malfunctions that result in disease (D. Murphy, 2008). Their definition of disease is based upon a departure from our shared and culturally defined ideas about human processes (D. Murphy, 2008). Health is seen as a condition of being able to realize goals. Thus health is not a specific, tightly controlled definition that involves the inclusion of well-being and the lack of disease. This suggests that health is a state that exists on a continuum between the WHO's definition of health (World Health Organization, 1948) and Boorse's definition of disease (Boorse, 1975). It is not one

specific point, but is instead a wide range of states of being, some of which may be characterized by variations in normal functioning, but variations that do not interfere with the achievement of an individual's goals for existence (all of which may change on a on-going basis as the physical condition changes). Thus patients would have the ability to define the health of their labor based upon congruence with their goals for labor. When a patient's goals are achieved in a situation that involves a state of well-being and the lack of disease processes, labor can then be seen as healthy and good.

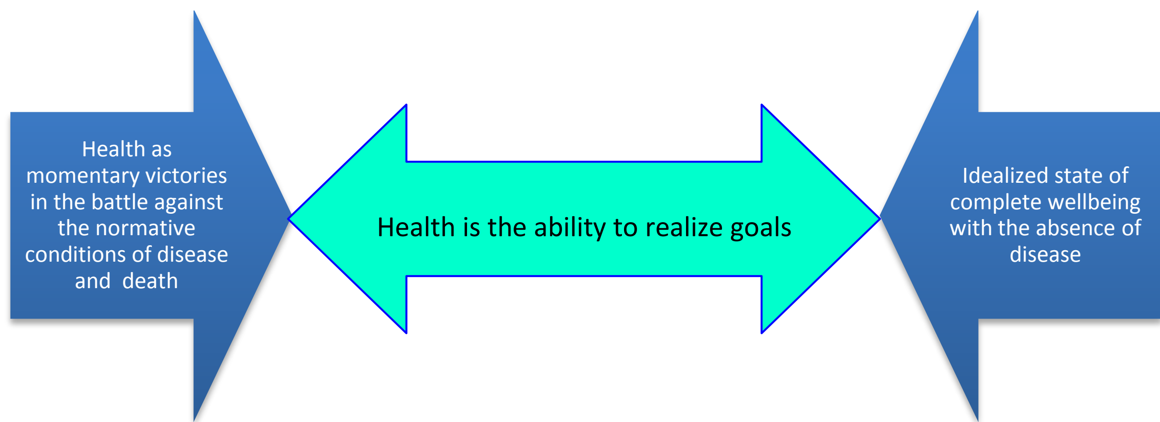


Figure 2: Health is the Ability to Realize Goals

The concept of salutogenesis is a theory of health, based upon the constructivist philosophy. Health, as understood within the conceptual framework of salutogenesis, is defined as the presence of a dynamic state, whose origin is within an individual's global orientation to life. Salutogenesis frames health care as a process of promoting and facilitating health, instead of focusing on curing illness through risk-based pathology diagnosis and bio-medical intervention. In general terms, this definition of health focuses on the positive, instead of definitions characterized by the negative '*absence of'* phrases.

Aaron Antonovsky coined the term salutogenesis in 1979 (Antonovsky, 1979), as he was reporting on his work with survivors of the Holocaust concentration camps. As a

researcher primarily interested in identifying a link between stressors and disease, Antonovsky discovered the role of tension management in the lives of impoverished people that seemed to afford some of them protection against the effects of stress. This discovery lead to a research concentration on why some people experience breakdown, resulting in disease, while others resist this breakdown, remaining healthy. With research involving three different vulnerable groups of Holocaust survivors, the poor, and American black populations, he found that individuals possessing confidence in their ability to predict and cope with their stressors, called a sense of coherence, were able to successfully manage stress and tension. This sense of coherence leads to personal well-being, even in apparently extreme circumstances and is analogous to a protective barrier. Key components of this sense of coherence include: comprehensibility, manageability, and meaningfulness (Antonovsky, 1979, 1993). People have to understand their own lives, and they have to be understood by others. They have to perceive that they are able to manage the current situation and perceive it is meaningful enough to find motivation to continue. This coherence develops out of a person's life experiences and is linked to their social and cultural history. Humans cannot and do not exist in a vacuum.

Salutogenesis involves a focus on overall health. Instead of focusing on risk factors, factors that result in disease or illness, a salutogenic orientation would focus on factors that support or maintain health, similar to preventative health initiatives. The linguistic relativity of this view of health is reflected in a viewpoint that health is a positive force towards the fulfillment of life's goals. According to a former surgeon general of the United States, this worldview is founded on the belief that life will eventually end, but that our health goals should involve making the best out of our time

here (Wagner, 1994). Health care is viewed as an assistant to help the person in healing themselves. Health care has an agentive role, but it does not control our behavior. People are the accumulation of their body, mind, and spirit in their personal environments, and cannot be treated without acknowledging the whole of the individual. Through gaining an understanding of the whole person, the health care provider is then equipped with the knowledge to evaluate the presence of health or un-healthy processes.

Integration of Salutogenesis and nurse-midwifery philosophy.

The integration of salutogenesis within nurse-midwifery practice can be revealed by evaluating the theoretical origins of the American College of Nurse-Midwives' (ACNM) philosophy statement (Cragin, 2004; Nickel, 1992; Tomey, 2002). Originally written in 1969, the ACNM's philosophy statement was based upon Ernestine Wiedenbach's philosophy of nursing, which describes a nurse first identifying a need-for-help prior to instituting patient centered nursing care (Cragin, 2004; Nickel, 1992; Tomey, 2002). Nurses must have a fundamental purpose, evolving out of their reason for being, that results in an action aimed at fulfilling their purpose in the context of the current health care situation (Nickel, 1992). To formulate nursing action, nurses must use their knowledge, judgment and skill to identify the need-for-help, provide that help and then validate the effectiveness of the help that was given. Nurses are agentive to the patient, but do not act independently of the patient's particular need for help. To this extent, a nurse's action is based upon a respect for the dignity, worth, autonomy, and individuality of each person, allowing patients the ability to maintain and sustain themselves. These beliefs, through Wiedenbach's interpretation, became the foundation for the ACNM philosophy.

Philosophy and belief statements are common in nurse-midwifery and midwifery texts (Ament, 2007; Jacobs, 1993; H. Varney, 1980; Helen Varney, 1987; H Varney et al., 2004). Nurse-midwives are taught the tenets of nurse-midwifery philosophy during their educational processes. Nurse-midwifery educational programs in the United States teach this philosophy to students and it is embodied in the core competencies of the profession, on which the national certification exam is based (H Varney et al., 2004).

The professional organization of nurse-midwives, the American College of Nurse-Midwives, of which over 60% of the profession belongs, has a published philosophy statement that explicitly states the profession's belief in non-intervention in normal processes with the appropriate use of technology and intervention for current or potential health problems (Low, 2005). These statements are embedded in the habitus of the nurse-midwife. She/he is taught to believe as a student that physiologic birth processes are to be respected and should be the goal in everyone's labor. The dichotomy between this belief and the current context of intrapartum care in the United States is an issue that each nurse-midwife must come to terms with; sometimes even on a moment to moment basis.

The ACNM Philosophy Statement (Low, 2005) contains many passages that reflect the use of both active and passive agency by the nurse-midwife. The agentive ability of the nurse-midwife to move from functioning in an active role to functioning in a passive role is part of their belief system. Nurse-midwives must be able to use "watchful waiting and non-intervention in normal processes" while at the same time appropriately use "interventions and technology for current or potential health problems" (Low, 2005). Health is denoted as an important goal but is also aligned equally with the

power and strength of women as agentive factors that result "in the well-being of families, communities and nations"(Low, 2005). Health is coupled with the normalcy of women's lifecycle events and the promotion of health is the goal of patient/ nurse-midwifery interactions. This alignment between health and normalcy, including the use of agentive action in the promotion of health, is a key connection that highlights important differences between the biomedical theories of health/ medical model and the constructivist theory of health/salutogenic model. Interventions and technology are specifically to be used only to address current or potential health problems. Disease or illness is not mentioned. Nor are any references that reflect processes indicative of the body as a machine.

Nurse-midwifery has strong ties to the implementation of EBP.

Midwifery care occurs at the intersection of a provider and a woman, instead of between a provider and society, as in the previous analysis of medical obstetrical practice. This focus on health care as emerging from an interaction between two individuals supports the definition of health that is dependent upon gaining an understanding of each person's specific goals, obtaining support, and achieving those goals. EBP requires direct input from both providers and patients in determining appropriate management of health care and require clinical expertise and knowledge of the most current scientific evidence. The intersection between nurse-midwives and their patients is an idealized location to study, implement, and evaluate EBP in birth management.

Why Study Nurse-Midwives?

Nurse-midwives are ideal health care providers to examine the behaviors that result in the use of EBP in birth processes. In the US, different types of midwives exist with varying education and roles. In this study, I concentrated on nurse-midwives, as they are the only state licensed, in-hospital, midwifery provider in the south-eastern US. Nurse-midwives have a dual role as both manager and provider of direct patient care. Nurse-midwifery as a profession has documented positive outcomes. Internationally, the profession of midwifery has been referred to as “the linchpin of the obstetric team and the backbone of modern antenatal and childbirth care” (Pettersson & Stone, 2005). Nurse-Midwifery in the United States is a growing profession with over 12,500 practitioners attending 11.6 % of all vaginal births (American College of Nurse-Midwives, 2012), an increase of 33% over the past decade (American College of Nurse-Midwives, 2008). Almost all (95.7%) of these midwifery managed births are taking place in the hospital environment (American College of Nurse-Midwives, 2008, 2012) where 98.8% of all births occurred in the U.S. (J. Martin et al., 2012). Previous studies of midwifery management of care, has concentrated on examining out-of-hospital birth (Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Davis-Floyd & Sargent, 1997; Jordan & Davis-Floyd, 1992). The practice of nurse-midwifery care is philosophically based upon the integration of best evidence, clinical expertise and patient’s input into decisions: working ‘with woman’ in a relationship to provide optimal outcomes (Low, 2005). Nurse-midwifery care is associated with a lower intervention rate (12.2% lower use of resources) and a lower cesarean birth rate (4.8% to 50% lower) when compared to physician managed labors after controlling for socio-demographic and medical risk

factors (Davis, Riedmann, Sapiro, Minogue, & Kazer, 1994; Mahoney & Malcoe, 2005; D Oakley et al., 1995; D. Oakley et al., 1996; Rosenblatt, 1997). The lower rates of intervention correspond with EBP aligned birth management practices. Currently, however, we don't understand why or how nurse-midwives are able to accomplish practicing in this manner.

The provision of nurse-midwifery care requires consultation, collaboration and referral as appropriate to meet the health care needs of their patients (American College of Nurse-Midwives, 2008). Nurse-midwives function within clinical microsystems (Nelson et al., 2001) consisting of small groups of people who work together to provide patient care. These microsystems exist in multiple sites: outside of the hospital, where prenatal care is provided, and on the hospital units that provide patient care during labor, birth, and postpartum. The microsystem is the convergence point between providers, information, and processes in the provision of care to meet the health care needs of patients (Nelson et al., 2001). These microsystems are embedded in, influenced by, and then influence the larger health care organization. These microsystems provides the 'field' (Bourdieu, 1977, 1990) in which CNMs demonstrate the behaviors of their practice of nurse-midwifery.

Nurse-midwifery is uniquely situated.

Nurse-midwives may have a uniquely situated knowledge of maternity care due to their dual role as manager and direct provider of care. The *feminist standpoint* philosophical view (Harding, 2004; Hartsock, 1998) provides additional insight as it provides understanding how nurse-midwives' dual role as manager and care-giver positions this profession to have a unique understanding of the practice of birth.

Standpoint theory recognizes that individuals (or groups of individuals) possess different knowledge of an experience due to their different roles and viewpoints of that experience (Harding, 2004). This is illustrated by the 'upstairs versus downstairs' view. When servants lived downstairs in the basement, they had significant information about the relationships that were happening 'upstairs' as they were the people cleaning the rooms, and moving between living spaces, hearing conversations, while the 'upstairs' elite moved according to the conventions of their society and were unaware of the happenings behind closed doors. Thus, the downstairs people had a greater understanding of the inner workings of the elite society than many of its members possessed. Nurse-midwives have a downstairs view of obstetric care, as they are often providing the care directly or coordinating care between the different providers that a patient interacts with, while physicians may be limited to an upstairs view, in which they make recommendations and leave it to others to implement. These understandings lead to the recognition of the nurse-midwifery profession possesses a situated knowledge of maternity care absent in the expertise of other providers (Hatem et al., 2008). This understanding of nurse-midwifery, as a profession which both manages and provides direct patient care, provided the inspiration to evaluate these professionals more closely.

Low rates of morbidity and mortality and no known adverse effects.

Outcome studies have compared the practice of nurse-midwifery to other providers, including obstetric and family practice physicians, and have demonstrated comparable or better outcomes (Downe, Simpson, & Trafford, 2007; Janssen, 2007; MacDorman & Singh, 1998; Mander, 1997; McCool & Simeone, 2002; P. Murphy & Fullerton, 1998; Nemcok, 1980; D Oakley et al., 1995; Rosenblatt, 1997; Sakala, 1988).

These outcome studies focus on issues of maternal morbidity and mortality which are relatively rare events and do not necessarily explain the differential management processes between the professions. Outcome indexes looking at optimal birth events have been developed (Cragin & Kennedy, 2006; Kennedy, 2006a, 2006b; P. Murphy & Fullerton, 2001), however these measures do not have a theoretical framework or linkage to clinical nurse-midwifery practice in the United States.

According to a review published by the Office of Technology Assessment of the US Congress: "Certified Nurse-Midwives (CNMs) are more adept than physicians at providing services that depend upon communication with patients…"(p. 5-6) which is central to the implementation of EBP (US Congress Department of Technology Assessment, 1986, pp. 5-6). In a recent Cochrane review, the authors concluded that when compared to other models of obstetric care, midwife-led care, based upon a philosophical approach to obstetrics that is grounded in normality (defined as selectively using intervention only when medically indicated), results in the provision of care that is associated with lower rates of morbidity and mortality and no known adverse effects (Hatem et al., 2008). When outcomes are compared to other obstetric providers with similar patient populations, researchers have observed that nurse-midwifery care is associated with lower rates of poor outcomes, lower rates of cesarean sections and lower instances of the use of birth interventions (MacDorman & Singh, 1998; Rosenblatt, 1997).

Thus, the position and role of nurse-midwives in the U.S. health care system makes CNMs outsiders and insiders, care managers and care providers, within the hospital environment. I argue that nurse-midwives are able to view birth from a different

perspective than the current mainstream managers of this process in the United States. As providers working within the health care system, nurse-midwives are able to use their leadership and behavior to possibly encourage changes that can lead to greater implementation of EBPs by all providers.

The process of nurse-midwifery is unknown.

Previously proposed models and frameworks of nurse-midwifery practice are largely constructed from theory (versus actual practicing nurse-midwives) and do not integrate personal values or the broader social environment. Internationally, midwives are recognized as educated professionals who work in partnership with women providing preventative care, promoting normal birth, detecting complications, appropriately intervening with medical care, and providing emergency care (International Confederation of Midwives, 2005). The midwifery paradigm consists of three defining characteristics which include acknowledgement of a mind body connection, working as part of a provider-patient team to create care plans reflective of the woman's perspective, and protecting and nurturing normality in women's health (Cragin, 2004). The translation of this definition and paradigm to the clinical practice of international midwifery has resulted in the formation of the midwifery model of care (Foster & Health, 2007). As proposed by Foster and Heath (2007), the midwifery model of care consists of three main spheres of activity. The caring sphere involves "being with women", listening to women and actively engaging in creating long-term continuity of care relationships. The clinical competence sphere is built upon specialized and contemporary knowledge in health care requiring analysis, judgment, decision making skills, and a willingness to question traditional practices in order to provide competent and safe care. The case

management sphere includes adept communication skills, the ability to function as a team player forming interdisciplinary, effective relationships and the perseverance to follow through until women's needs are met within the health care system. This model of care has been used successfully to frame education programs in the Dominican Republic (Foster & Health, 2007) and Guatemala (Foster, Anderson, Houston, & Doe-Simkins, 2004). In the U.S., the midwifery model of care has been discussed by scholars in some form since 1935. This model however does not explain the process of care of the practicing nurse-midwife. Also it does not address the integration of beliefs and values in the field of contemporary clinical practice.

Four studies over the past 40 years have examined nurse-midwifery practice in the United States for the purpose of explicating theories which describe practice and the connections between beliefs, values and practice (Kennedy, 1999; Lehrman, 1981, 1988; Thompson, 1989). These models all have similarities; however these studies do not illustrate nurse-midwifery beliefs and values are embodied in clinical practice. The authors focused on confirming components of the nurse-midwifery philosophy of the American College of Nurse-Midwives (Kennedy, 1999; Lehrman, 1981, 1988; Thompson, 1989).

The most recent research into models of midwifery involved an examination of exemplary midwifery practice by Kennedy in 1999 (Kennedy, 1999). Kennedy built a model of exemplar midwifery practice out of concepts obtained via a Delphi panel selected by leaders of two diverse midwifery practice organizations in the United States. The author tested the external validity of this model and demonstrated very low congruence with actual clinical nurse-midwifery practices (Lange, 2006). One potential

reason for the low congruence with current nurse-midwifery practice is that many members of the Delphi panel practiced prior to the early 1990's, thus the final model reflects an earlier period of clinical practice within a different obstetrical climate and therefore, a different institutional milieu.

Thus, the theoretical foundations of nurse-midwifery practice in the United States reflect clinical nurse-midwifery as it was practiced prior to the 21st century. However, the nurse-midwifery practice role is in a state of continual evolution within a changing obstetric climate. *A theoretical understanding of how nurse-midwives implement evidence-based obstetric practice within the US health care system and how the beliefs and values embodied in nurse-midwifery practice are influenced by the social, structural and interprofessional environments has not been previously proposed*. The current study into the practice of nurse-midwifery in the United States hospital system aims to fulfill this gap in knowledge. The current childbirth environment is very different from the environment in which the profession was created. Nurse-midwives must interact collaboratively with other health care providers, yet still meet the needs of the women they serve, all the time seeking to implement evidence-based care. Beliefs, values, and the practice environment all influence behavior and are thus integral to the provision of care based upon the best evidence, clinical expertise and patient preference.

Significance

This study is well aligned with the Agency for Health Care Research and Quality's mission focusing on improving the quality, safety, efficiency and effectiveness of health care (Association for Health Care Research and Quality, 2008). This proposal also aligns with goals from the Healthy People 2010 (U.S. Department of Health and

Human Services, 2000), National Priorities Partnership (National Priorities Partnership, 2008), National Quality Forum (National Quality Forum, June, 2009), World Health Organization (WHO) (World Health Organization, 1997; World Health Organization Department of Making Pregnancy Safer, 2007), Institute of Medicine (Institute of Medicine, 2001), the Partnership for Safe Motherhood and Newborn Health (The Partnership for Maternal Newborn and Child Health, 2005), Save the Children Foundation (Save the Children, 2008), and the Coalition for Improving Maternity Services (Coalition for Improving Maternity Services, 1996) to minimize overuse and misuse while supporting the use of EBP in the management of labor and birth. The results of this study will have implications for understanding the current process of hospital-based nurse-midwifery care and the identification of areas in which interventions can be implemented to increase the use of EBP. By understanding the factors that influence the use of EPB by nurse-midwives, educational programs and practicing nurse-midwives will be able to recognize their own embedded values and work towards positively changing norms which is the first step towards improving patient outcomes. Becoming aware of the techniques that nurse-midwives apply while providing evidence based care, will allow other professions to self-reflect on their processes of care. In this manner, obstetric professionals may learn different ways of approaching birth that support EBP. Through conscious recognition of areas in which changes can be made to support EBP, nurse-midwives and other obstetric care providers can individually or collectively make changes or implement procedures to maximally support evidence-based maternity care.

In summary, the United States has an expensive health care system in which interventions are often misused according to the most current scientific evidence, which result in significant expense without concomitant evidence of quality. There is scientific evidence that nurse-midwifery care yields quality outcomes with higher patient satisfaction, lower morbidity and mortality rates, and less use of expensive interventions than other obstetric providers. This study will illuminate the attitudes, values and beliefs of the current practice of hospital based nurse-midwifery and describe the social, structural, and interprofessional environments that positively and negatively affect the behavior of nurse-midwives, focusing on the use of EBP in labor and birth management. This study makes a new contribution to health care literature, laying the groundwork for a future research agenda aimed at minimizing the overuse, underuse, and misuse of obstetric interventions for *all* health care providers. As discussed in Chapter 1, such research may lead to less expensive care without the loss of safety, quality, and efficiency in the care of childbearing women.

The results of this study have important implications. It will provide an understanding of the current process of hospital-based nurse-midwifery care and it will identify areas in which further study may result in proposals for all obstetrical providers to increase the implementation of EBP. The focus of this study is how this profession provides care that is associated with EBP outcomes, while dealing with multiple factors that influence these interactions. Uncovering this process, in the profession of nurse-midwifery, is an initial step towards gaining an understanding of factors that hinder mainstreaming EBPs in the management of birth within the United States.

Chapter 3- Research Design and Methods

Methodologies

Constructionist grounded theory.

I chose three analytic strategies to explicate the process of nurse-midwifery. These included constructionist grounded theory, situational analysis, and discourse analysis. Constructionist grounded theory methodology facilitates the in-depth understanding of the processes of a phenomenon, in this case, nurse-midwifery practice. This construction of theory is inductive, coming out of the experiences of nurse-midwives in practice who are currently supporting birth in the hospital setting, focusing on the use of EBP's.

Theoretical construction and process description are two main goals of grounded theory research. According to Morse (2001), grounded theory requires the elucidation of stages or phases, uses gerunds (words with –ing ending) which are reflective of action or change, revolves around a core variable or category and, while abstract, makes the blend of the data visible in its descriptions. Constructionist grounded theory is different from classic grounded theory. This approach assumes a relativist epistemology; meaning that the outcome is reflective of the specific situation of the study participants and researcher. It embraces the view that processes occur within the context of an environment that includes both internal and external influencing factors and actors (Charmaz, 2009c). The researcher engages with and interprets participants meanings and actions in the context of larger social structures and discourses, of which the participants may be unaware (Charmaz, 2009c). Using the constructionist standpoint, diverse theoretical starting points can be invoked to open inquiry and drive data collection. During data collection,

constant comparative methods were used, allowing for the evaluation of relationships between concepts and categories (Charmaz, 2006). This permitted explorations of various aspects of the process as they became identifiable. Uncovering this process was the central aim of my dissertation.

Situational analysis.

Situational analysis (Clarke, 2005) was used as an additional methodological tool for articulating the various components of the nurse-midwives' process of care and examining the relationships between these components. I used this analytic technique to reveal a social world/arena map showing collective actors and elements for a meso-level interpretation of the field surrounding the newly discovered theory of the nurse-midwifery process, thus describing its field. Situational analysis is a method that has evolved out of grounded theory, drawing together studies of discourse, agency, action, and structure to analyze complex situations (Clarke, 2005). At the core of situational analysis is an orientation around social worlds/arenas/negotiations instead of the basic social process in grounded theory. The initial approach of analysis is similar to grounded theory, in that the researcher analyzes the text for understanding via the use of codes. However, these codes are not actions, as in grounded theory; these codes are factors that influence the action. Situational analysis begins with the identification of the many various components of the situation, and then through the use of visual "cluster" maps, relationships are schematically represented. The situation is the unit of analysis and understanding the components of the situation and their relationships is the goal of this process (Clarke, 2005). The process of creating these maps is recursive throughout the entire analysis, until saturation occurs and no further linkages are identified (Clarke,

2005). Situational analysis is used to supplement constructionist grounded theory and to illustrate the dynamic interpretive and constructionist focus (Clarke, 2005).

Discourse analysis.

Discourse analysis was used to engage the transcribed texts that result from the interviews with the goal of exposing the values and beliefs embedded in the nurse-midwifery process of care. In examining the linkages between salutogenesis and nurse-midwifery philosophy, discourse analysis was the primary methodology used to uncover the congruence between these belief systems. "Discourses are distinguished both by their ways of representing, and by their relationship to other social elements" (Fairclough, 2003, p. 129). The process of discourse analysis uncovered the linguistic structure of nurse-midwifery communication and provided greater detail to the habitus and capital of nurse-midwifery behavior. Discourse analysis can be used to examine social action by examining how actions and meanings are constructed through text and talk (Nikander, 2008). I examined the values and beliefs exemplified from words that nurse-midwives used to describe their behavior and analyzed them from a perspective of discourse. The specific type of discourse analysis that was used is thematic analysis. This process involved identifying themes which were used as codes. These themes were then organized into thematic clusters at higher levels of analysis. The key to discourse analysis is recognizing the use of specific terminology which can reveal how connections are made and understanding is obtained. *Genre*s are ways of acting within discourse (Fairclough, 2003). They can be general, i.e. information transmission can take the form of casual conversations, narratives, or verbal reports. Or they can specific and tied to a particular group or situation, such as the genre of a nursing research presentation at a

contemporary professional conference. The genre I focused on was the text that is created by transcribing interviews. Within this genre, I used the identification of intertextuality to analyze the values and power involved in the process of nurse-midwifery care. Identifying intertextuality involves detecting the presence of other "voices" embedded in the speaker's words, along with looking for meanings which signify action, representation, and identification, and locating hybridity (mixtures of practices, beliefs, forms, etc.) (Fairclough, 2003). In this research, specifically, I was looking for moments in the text when the nurse-midwife used terms aligned with appreciation for medical intervention, non-medical intervention, or terms aligned with EBP. I also looked for situations where the nurse-midwife discussed the reasons why she was drawn to the profession and the descriptive words she used. These words, with further analysis, were the basis for gaining an understanding of the values and beliefs embedded in nurse-midwifery practice. Looking for *genre chains* (connections between genres which may reveal evolution of one to the next), *genre mixing* (combinations of genres which may reveal social change and agentive actors/elements) and *interdiscursivity* (analysis of the genres in the text to reveal social practices) was accomplished to expose potential actors/elements that may support or influence the habitus, field or capital of the practicing nurse-midwife. Through the mixing of the genres, the nurse-midwife may demonstrate that she values the implementation of research evidence in her provision of care. An example of this would be the nurse-midwife describing care with research terminology, thus exhibiting an appreciation for and/or embedding scientific evidence in her practice. Detection of these structures in the texts allowed for the exposure of hegemonic power structures and illustrated the use of

conscious or unconscious resistances or support of these power structures. Epistemic and deontic modalized clauses (shows assumptions and evaluations) were identified as evidence of the nurse-midwives' commitment or feeling of obligation toward specific actions (Fairclough, 2003). The terminology that the nurse-midwife uses as she describes medical intervention has the potential to reveal her inner feelings of appreciation or disapproval of these procedures and her values/beliefs in their use in healthy birth. Through discourse analysis, I was able to take a step back from the 'taken for granted' language we use in order to look for recurrent patterns in the language use of nurse-midwives, thus revealing their values and beliefs via their talk and texts (Nikander, 2008).

Study Sample

The study sample consisted of nurse-midwives currently in clinical practice and supporting birth within the hospital setting. The study participant inclusion criteria consisted of current ACNM or ACC certification as a nurse-midwife and licensure to practice in their location, currently practice in full-scope, full-time clinical midwifery with a hospital as their primary delivery site. More criteria included ability to be conversant in the English language, a minimum of three years of clinical experience as a CNM providing intrapartal care, but not more than 20 years of experience, ability and willingness to provide informed consent and participate in the interview process and follow-up contacts, and capable of meeting the primary researcher at an interview location within driving distance of Atlanta, Georgia. Exclusion criteria included prior personal familiarity with me or any of my dissertation committee members.

Justification for these inclusion and exclusion criteria was based upon the following specific decisions and information. This study focused on nurse-midwives who list the hospital as a delivery site because this is where 97% of all nurse-midwifery managed births are taking place and the factors influencing the implementation of evidence-based care could be expected to be different in birth center and home birth locations. Birth center and home birth environments are contextualized in a different organizational field and many factors associated with power and control over behavior would be different. Interviews took place in English and all of the participants were all conversant in this language. The requirements of between 3 and 20 years of clinical experience were included because, according to Benner, at least 3 years of working with the same population is required prior to obtaining proficiency in practice (Benner, 2001). Proficient nurses perceive situations in their entirety and can contextualize interactions in terms of long-range goals (Benner, 2001). This level of expertise is required in order to accurately provide qualitative data to illuminate the process under analysis. An upper limit of 20 years experience was set, due to the desire to reflect current nurse-midwifery practice based upon the recent changes in the health care system and not habits or beliefs created prior to the recent changes in obstetric health care practice.

Participant enrollment.

Identification of the participants was done using the snowball technique after discussing the project at meetings of CNM's occurring within driving distance of Atlanta, Georgia. Stratified, purposive sampling was employed in order to assure maximum variation in the sample (Waltz, Strickland, & Lenz, 2005). Participation was solicited at American College of Nurse-Midwives (ACNM) Affiliate meetings in Atlanta, GA and

Orlando, Fl. Both of these meetings were open, meaning that membership in the ACNM was not required to attend and participate in the discussion. At the conclusion of each interview, participants were asked to recommend additional nurse-midwives for potential participation. Stratified variation in subjects was sought in order to initially gather the breadth of the topic prior to using theoretical sampling to gain depth. The participants were purposively solicited for variation in practice size (1-5 CNMs vs. 6+ CNMs), hospital level (levels 1-2 vs. level 3), total number of births managed per month (0-10 births per each CNM in practice vs. >10 births per each CNM in practice), and variation between rural and urban practice settings (rural/suburban vs. urban/inner city) (See below table). Each participant's information was placed into a table according to their individual characteristics listed on each row and checked off according to their specific attributes as listed in the columns. The goal of doing this was to enroll maximum variation in each category in order to achieve sample variation adequate to cover potential differences in practice related to these specific characteristics.

Table 1: Study Participants			**Total (n=19)**
Practice Size	1-4 CNM partners	5 or More CNM Partners	
	9	**10**	**19**
Total births per month	0-10 births per month	Over 10 births per month	
	10	**9**	**19**
Practice Setting	Rural or suburban	Urban or inner city	
	13	**6**	**19**
Hospital Level	Level 1 or 2	Level 3	
	8	**11**	**19**

Consent process.

After receiving contact information concerning the potential participants, I sent emails to potential participants soliciting their voluntary participation in the study. I then

contacted potential interested participants via telephone to confirm that they meet the eligibility criteria using a prepared screening form. Then, I explained the purpose of the study, what participation entailed, potential risks and benefits of participation, and measures that were used to ensure informant confidentiality. I assured potential informants that their participation was completely voluntary, that they may withdraw from the study at any time without negative repercussions, that the risks of participating in the interview were minimal, such as time to complete the interviews, and that there are no known benefits to them from participating in the study apart from the knowledge gained.

I also explained to the participants that they would be given a unique study identification number, that any personal information that might be used to identify them will be removed from the data following the interview, and that the information gathered would be combined with that of all participants during the analysis. I then asked the potential informants if they had any questions and invited them to take part in the study. For those who wished to participate, I scheduled a convenient date and time for the interview. On the scheduled date of the interview, I reviewed the informed consent protocol, answered any remaining questions, and obtained their written informed consent to participate in the audio-recorded interview.

Interview procedures.

Emory IRB gave exempt approval (see Appendix 1). Also, the American College of Nurse-Midwives (ACNM) approved the request to solicit their membership for participation in research (see Appendix 2). I personally conducted all of the interviews in the setting of the participant's choice which lasted between 60 and 120 minutes. These

settings varied from the participant's home, to public restaurants, to their work environment. A semi-structured interview guide provided a framework for the interviews (see Appendix 6). This interview guide was designed to be flexible so that questions could be adapted to fit the participants' perspectives, while at the same time providing standardized direction to the interview. This interview guide was created with the assistance of members of my dissertation committee, all of whom possess expertise in qualitative methods. Additional input was given by experts in interviewing and qualitative methodologies, including Kathy Charmaz (Charmaz, 2009a, 2009b), Ray Maietta, Ph.D. (Maietta, 2009a, 2009b), a qualitative research consultant at Research Talk, Inc. and Monique Hennink, Ph.D. (Hennink, 2009a, 2009b), of the Rollins School of Public Health at Emory University.

The completed interview form, study screening form, demographic and personal information form, and the associated audiotapes, were labeled and stored in a secure location at the Nell Hodgson Woodruff School of Nursing (NHWSON). According to institutional policy, all hard copies of the instruments will be shredded and the audio recordings will be erased after seven years. Standardized procedures and protocols were established to minimize risks, including risks to confidentiality. These included: 1) coding the data using individual identification codes, 2) no storage of names with identification codes, 3) keeping all data in a locked file cabinet at the NHWSON; and 4) allowing only myself and my dissertation committee access to the raw data without a data sharing agreement. All computer databases were password protected. Any publications resulting from the study will neither name individual participants nor describe them in any personally identifiable way.

I focused my questions on the use of three specific practices (oxytocin administration for induction or augmentation, medical pain relief including epidurals, and cesarean birth decision making) with high levels of evidence resulting in specific recommendations and documented overuse and/or misuse resulting in elevated health care costs. Each of these practices, all of which may be implemented during nurse-midwifery patient management, have clear recommendations for implementation based upon research evidence: *oxytocin administration for induction or augmentation*, (Albers, 1996; Alfirevic, Kelly, & Dowswell, 2009; Howarth & Botha, 2001; J. Martin et al., 2007; McCool & Simeone, 2002; Simpson & Poole; S. Tracy & Tracy, 2003; World Health Organization, 1997) *medical pain relief including epidurals*, (Anim-Somuah, Smyth, & Howell, 2005; Carvalho, 2006; McCool & Simeone, 2002; Nystedt, Edvardsson, & Willman, 2004; Poole, 2003; Torvaldsen, Roberts, Bell, & Raynes-Greenow, 2009; World Health Organization, 1997) and *cesarean birth* (Chaillet & Dumont, 2007; J. Martin et al., 2007; Maternity Center Association, April, 2004; McCool & Simeone, 2002; National Institute of Health, 2006; National Institutes of Health, 2006; NIH, 2006; S. Tracy & Tracy, 2003; S. K. Tracy, Sullivan, Wang, Black, & Tracy, 2007; Viswanathan et al., March, 2006; World Health Organization, 1997; Young, 2007). All of these procedures may require physician consultation, collaboration, or referral to implement. However, it is the nurse-midwife, functioning as the manager of her patient's labor and birth, who makes the patient assessment and determines when she believes these interventions are needed prior to initiating physician involvement in care.

The outcome of this study evolved out of 19 in-depth interviews with nurse-midwives in the southeastern United States. The nurse-midwives were very open and

forth-coming about their thoughts, feelings, and actions. They were very interested in sharing their experiences. Many actually said they enjoyed talking about their experiences. The interviews flowed smoothly, with the nurse-midwives often volunteering more background to their stories and required minimal cueing to provide more detail. Many of the nurse-midwives reflectively analyzed themselves during our discussions, often becoming personally aware of when their own actions would conflict with established professional beliefs. These insights were enlightening as they lead to a more detailed understanding of where current beliefs conflict with publicly known professional stereotypes and beliefs. The initial interviews were broad-ranging and the ones completed near the end of data collection targeted detailed information about the evolving process of care. The process of care was discussed with the concluding nurse-midwives who acknowledged they could see their practice revealed and reflected in the theory.

At the conclusion of the interview, the demographic and personal information form (DPIF- see Appendix 2) was used to obtain information descriptive of the nurse-midwife's practice and personal characteristics including: age, gender, racial/ethnic background, educational background, years of clinical practice, year initially certified, location of practice, number of deliveries per month, and racial/ethnic characteristics of their patient population, size and characteristics of practice setting and office/ on-call schedule. This data was self-reported by each participant at the conclusion of their interview, and was based upon their own familiarity with their practice demographics and not on documented statistics. Demographic and personal information from the DPIF was evaluated using descriptive statistics as a means to describe the characteristics of the

participants (Waltz et al., 2005). Twenty individuals were interviewed during the course of this dissertation. One interview was eliminated, due to participant certified longer than the specified inclusion, exclusion criteria. She did not practice every year since she was certified and thus considered herself possessing less than 20 years of experience, despite being certified for over 20 years. She reported during pre-screening that she practiced less than 20 years and the interview took place. Upon her completion of the DPIF at the conclusion of the interview, I became aware of the discrepancy and the interview was not entered into data analysis.

Table 2: Statistical Description of Participants (n=19)	Ave	min	max
age	48.15	28	64
year first certified as cnm	2000.05	1991	2008
years in clinical practice	10.8	3.5	20
number of cnms in practice	5.5	1	9
average hours in office per week	28.85	10	60
average hours in hospital per week	48.8	17	168
number of mds in practice	5.5	1	32
number of nps in practice	0.6	0	3
number of pas in practice	0.45	0	4
max births per month	20.45	3	60
min births per month	11.75	0	55
practice population of participant: class %			
(% of each as reported by participant)			
lower class	26.75	0	100
working class	33.45	0	69
middle class	29.65	0	50
upper class	8.9	0	50
total class	98.75		
Practice population of participant: Ethnic background			
(% of each as reported by participant)			
hispanic or latino	24	1	56
non-hispanic or latino	76	44	99
Total	100		

Practice population of participant: Racial background (% of each as reported by participant)			
American Indian or Alaskan native	2.05	0	40
Asian	6.7	0	30
native Hawaiian or other pacific islander	0.55	0	10
black or African American	30.8	3	75
white or caucasian	59.9	5	96
practice population: total class %	100		

Table 3: Categorical Descriptions of Participants

Ethnic Background of participant	Non-Hispanic			Hispanic		Total
	19			0		19
Racial Background of participant	American Indian or Alaskan native	Asian	Hawaiian or Pacific Islander	Black or African American	White	Total
	1	1	0	2	15	19
Practice Location	Rural	Suburban	Urban	Inner City		Total
	1	12	5	1		19
Employer	Hospital	HMO/Government	Private Practice			Total
	12	1	6			19
Level of Hospital in which participant provides care	Level 1 (well baby care offered)	Level 2 (special care nursery for babies over 32 weeks)	Level 3 (intensive care nursery for babies of all gestational ages)			Total
	5	3	11			19

Description of participants.

In the year 2000, the average age of a practicing nurse-midwife was 46.7 (K.D. Schuiling, Sipe, & Fullerton, 2005). In the year 2008, the average age of a practicing nurse-midwife was 50.76 (K.D. Schuiling, Sipe, & Fullerton, 2010). In the current study, the average age of the participant was 48.15 and is thus just under the current average within the profession. The typical nurse-midwife in my study also was female, Caucasian and obtained her certification in 2000. Nationally, the nurse-midwifery

profession is mostly female (98%) and Caucasian (91%)(K.D. Schuiling et al., 2010). She may work as an employee of a hospital or as an employee of a physician owned practice. She is part of a nurse-midwifery group and typically has 5 partners. She works an average of 29 hours per week in the office and 49 additional hours per week in the hospital for a total of approximately 80 hours of her time per week devoted to her profession. The nurse-midwives, participating in this study, provide care to women of varied socio-economic and racial, ethnic backgrounds.

Data Analysis

The first step of implementing the method of constructionist grounded theory involved transcribing qualitative data from the interviews, observational notes and memos that were created during data collection and analysis. Transcriptions were created by me and a paid transcriptionist. After receipt of digital transcripts, each document was read through in its entirety, checked against the audio recording for accuracy, cleaned, and entered into the qualitative management software program, MaxQDA, as a primary document with an assigned document identification code consisting of an alphanumeric combination. As each new primary document was entered into the software program, processes were identified and coded with new or existing codes. A constant comparative approach to data analysis was used. With this process, I evaluated the documents recursively. As new documents and codes were added, I reviewed and re-coded the initial documents with the insights gained from the subsequent ones. Coding was also cross-checked with previous primary documents to ensure consistency. Each document was examined, line by line, to identify processes and actions, using gerunds as codes. Codes were delineated after preliminary identification within and across the primary

documents. All codes were assembled as a unit, reviewed for exclusivity of its definition and compared between documents. As new codes were identified, these were compared with previous codes for congruence and organizing preliminary themes. Code clusters were grouped with rationales underlying the clustering noted in memos. Further reduction in the numbers of code clusters resulted in identification of themes. These themes were scrutinized in order to uncover the embedded social process present which is presented as the final outcome model. Validity in the data analysis phase was obtained through a process by which experts in qualitative analysis review text and coding to verify accuracy in the constructs identified from the data. The review and verification of the coding process by faculty engaged in qualitative research took place concurrently throughout the analysis process to maintain internal validity, reduce bias, maintain consistency in methodology and assure credibility in the outcome (Miles & Huberman, 1994). See table 4 for examples of coding using the various methodologies involved in this research study. Alphanumeric codes were replaced with a generic name for data description and quoting purposes.

After the analysis of the first five participants, additional interview questions were constructed and added to the interview questionnaire. These questions (listed in appendix 6) were aimed at gathering additional information about the emerging social processes. Probing questions were added throughout all interviews when the participant hinted at a topic, but did not spontaneously go into detail on that topic.

Simultaneous with the coding for the process of nurse-midwifery care, I also coded for text segments that would reveal the values and beliefs held by the nurse-midwives and segments that would reflect their power to act in the way they desired in

the management of the birth process. These text sections were then categorized into basic themes reflective of specific values and beliefs. The transcripts were analyzed for evidence of the participant mentioning things that they liked, disliked, felt strongly about, cared about, things that drew them to the profession of nurse-midwifery, and things they would like others to think about them as providers. These codes were then analyzed in their textual context using the techniques of discourse analysis, in order to expose the various beliefs and values of nurse-midwifery care. Specifically, I looked for areas where the terminology that was spoken by the nurse-midwife revealed their values and beliefs. After identification of commonalities, the codes were then broken down into three categories. The first was inner beliefs and values: those that are internal to the nurse-midwife; the second was interactive beliefs and values: those that focus on relationships between individuals; and the third included process beliefs and values: those that focus on the management of birth.

I also coded for factors that affect the process, the first step in implementing the situational analysis methodology. The documents were reviewed for people, things, situations, historical factors, environmental factors, emotions, and feelings that the participants mentioned during their interviews. These codes were assembled into a messy working map (see figure 3). Working with literature review, review of current topics in obstetrical news, review of lay literature about birth, review of the websites of the American College of Nurse-Midwives, American College of Obstetrics and Gynecology, World Health Organization, Lamaze International, among others, and brainstorming with members of my dissertation committee, additional factors were added to answer the question who and what affect the process of nurse-midwifery care in the

hospital. The messy working map was filled out until saturation occurred and no additional factors could be identified. I wrote the factors on the large pages from an easel pad to visualize these codes and identify their relationships (Figure 3 and Figure 9). These codes were then organized into an ordered situational map (Figure 10) for the purpose of understanding the relationships between these factors and their impact upon the process of care (Clarke, 2005). I then proceeded to start relational analyses (Figure 11) by asking what nurse-midwives say about each of the factors. To answer these questions, I went back to the transcriptions and/or added additional questions as I continued to do interviews to gather this data. The next step of the process was to understand the larger social world in which the nurse-midwifery process was taking place. Focusing on the three major providers of care at birth, nursing, nurse-midwifery and medicine, I then went on to describe how the factors influence these providers and their social, collective worlds. Throughout this process, I created memos within the MaxQDA program and in a journal that highlighted my decision-making.

Table 4: Exposing the Analysis:
Examples of coding via each methodology highlighting sample analysis of text segment

Method of analysis	Why use this method?	Data source	Examples of codes	Example text segment as basis for example analysis	Example analysis
Descriptive coding	Used as preliminary qualitative technique to identify text for purpose of doing discourse analysis and situational analysis Goal is to identify text for use in Discourse analysis and	Text from interviews, codes emerged straight from words in text	Community affecting care history affecting care feeling isolated feeling frustration Values quality and safety in birth values responsibility	*I think some people actually think that continuous fetal monitoring is actually a great thing, like they can see what is going on with their baby constantly. Some people sit there and watch their baby during their whole labor and I think our society thinks that you know that like that type of technology must only make things better. So I think it comes from a lot of angles, but I think it is an expectation of society.*	Code: community affecting care of nurse-midwives. This segment of text refers to the expectation and appreciation of fetal monitoring in labor that is based upon a community expectation that this is always used in labor… that seeing your baby on the monitor “makes things better”. This

	Situational analysis.		values relationship with patients	*Beth, section 60*	expectation results in nurse-midwives being pressured to always use this technology on their patients during their labor management.
Discourse analysis	To look for connections between the words/ terminology that nurse-midwives use in their language and identify values and beliefs reflected by those segments of text. Goal is rich description of the habitus of nurse-midwifery care.	Sections of text from transcribed face to face interviews identified by descriptive coding.	Values medical model values problem solving values normal processes of birth Values vaginal delivery	*I've been really involved in the community in terms of, I'm trying to think of how I could word this, in this community, what I see is that there's been in the past, a big disparity between the natural birth people and the hospital intervention people. And I see that that big divide has done nothing, in terms of the quality of care in this area, other than put VBACs at home, which I'm not a supporter of at all, and to me, could cause more harm to women. So somewhere in my head, as much as I am a birth center midwife deep down in my heart and love that, where I stand is that women get choice, informed choice. And it's not for me to say whether or not you should get an epidural or not get an epidural personally. It's your choice, based on the facts that, of informed consent. In fact, it was interesting, somebody just had me read the Bradley Book, and I've never read the Bradley Book and I have a lot of negative things that I feel about Bradley, other than I like the dads being involved. And I said to her, I can't support this. This is fear-based, telling women that they might die when they have an epidural is fear-based, and I won't do that. I'm not bringing fear either way. I will not, I am standing, the birth must be peaceful. Therefore, if you're radical, go have your baby at home because birth needs to be peaceful, there doesn't need to be the- you come in and we're on the opposite side. I think that that's happened to births in this community, that people come in and they feel like all physicians are out to induce you and to do unnecessary interventions*	Memo about section: This passage is where the nurse midwife discusses the whole lay midwife versus hospital midwife argument. And how she came to see that intervention was not bad. There is a focus here on individualizing care and achieving goal of vaginal delivery in the context of a good experience. Codes pertinent to Discourse analysis: Values working as part of a health care team, values choice in labor, values safety, quality in birth, values medical model, values individual, appropriate use of intervention, values vaginal delivery. The CNM sets up an initial contrast between two groups of midwives. These are described as the natural birth people and the hospital intervention people. Using these terminologies, she is embedding specific social practices into both of these locations. The assumption here is that providers managing home birth are advocates of no intervention in birth while providers managing hospital birth are advocates of intervention in birth. This extreme dichotomy reveals the footing of the speaker; she is categorizing herself as one of the intervention people. As a nurse-midwife who works in the hospital setting, her language reveals that she is dealing with internalizing (what could be seen as)

				and that's not helpful. That you need to, number one, pick team players. We're all on the same team here. Everybody in women's health wants a good outcome. People do not set out, for the most part, to give you pit because they want to go to the golf course. I don't believe that, at least the physicians I work with. And that, I think that they're – and my opinion, part of midwifery is to give informed consent, and there's not informed consent about this. Most people – I have a woman that is a gestational diabetic, diet controlled, has had perfect blood sugars, is 40 in a couple of days, and wants to be induced, and I'm like, okay, well, this is the deal, your cervix isn't doing anything. We induce too early; you increase your risk of C-section. I do? Yeah. You do. That's informed, somewhat, of informed consent. And I think that that's, women need to get choice based on informed consent, and it's their choice. Whether or not I like it, it's their choice. Gale, section 76	discordant beliefs. She appreciates non-intervention (she describes herself as a birth center midwife deep down) but she holds more strongly that patient choice is the key to management and this trumps her belief in non-intervention (part of her habitus). Yet, aside from calling herself a birth center midwife, the terminology she uses to describe birth aligns her with the medical model. The CNM is using terms from the linguistic marketplace of medical management. These terms (i.e. *VBAC, gestational diabetic, diet controlled, blood sugars, induced*) are used freely without explanation, which reflects her comfort with the ordering and implementation of these interventions. The introduction of these terms are done in a ritualized manner, as an exchange between one hospital based health care provider to another, each with a shared linguistic vocabulary (using terms from the same linguistic marketplace), which separates this nurse-midwife from the natural birth people. These words reflect the presence of social distance between the two types of providers and links unsafe care, fear tactics, and non-peaceful deliveries to the natural birth providers, thus shifting power over the better management of birth to the hospital interventionists. Then, the CNM softens the stereotype of the hospital interventionist by aligning them with a support of patient choice and team work.

					This shifts the power exemplified by a hospital interventionist to the patient, thus increasing the agency of the patient in the management of their own labor, which is assumed to be one of the patient motivations for seeking out of hospital birth. Also in this text is an interesting link between the discourse of natural home birth vs. interventional hospital birth and the Bradley method of birth. Introducing the discussion of the Bradley method into this discussion, reveals that the nurse-midwife is linking fear-based rhetoric to the providers of home birth resulting in the creation of an experience that is viewed by this nurse-midwife as being non-peaceful. The introduction of this discourse is used by the CNM to legitimize her alignment with hospital based birth. At the conclusion of this segment of text is the recollection of a verbal exchange between the CNM and her patient. The discussion begins with the patient requesting an induction, which might be justified by the patient’s medical condition. However, the CNM, shapes the patient’s desire for this intervention by linking induction of a non-favorable cervix to the (contextually negative) outcome of a cesarean. Via the patients acceptance that this is not the outcome she desires, a caesarean birth is exemplified here as the non-ideal delivery route- thus revealing vaginal delivery as the preferred delivery route of this CNM.

Situational analysis	Identify the myriad of factors that affect the provision of nurse-midwifery care.	Text from interviews, research-based literature, internet research, lay literature, brainstorming sessions with nurse-midwives, literature from professional organizations and consumer groups concerning birth.	Role/purpose of labor in a woman's life History of midwifery in the United States Women's bodies as machines Discourses about agency, individualism, power Marvels of modern medicine: Everyone expects a perfect baby	*Health is the success of external agents (treatments) over nature in temporarily eliminating disease or other pathological conditions from the body. Nevertheless, the risk, whether high or low, of disease or death remains. Disease results from the failure of the external agents and, therefore, the failure of the individual and the medical care system. The ultimate failure of the individual and the physician is death: the greatest enemy, against which an all-out struggle must be waged.* (Wagner, 1994, p. 28)	Biomedical theory of health views physicians as warriors in a fight against disease that ultimately results in death. Humans fail, just like machines do, and this failure results in disease. These statements are reflected in situational codes of women's bodies as machines, technology seen as life-saving, ultimate control of birth by MDs, Role of MD's in birth, history of birth, role of intervention in labor, Risk in labor.
Construct-ionist grounded theory	Identify process used by nurse-midwives in their provision of care. Focus on actions that are associated with choices in labor and birth management in the hospital setting.	Text from transcribed face to face interviews with nurse-midwives. Texts from memos written about the interviews and during analysis process were also used to identify and refine process.	Buffering the nurse protecting patients from being railroaded using intervention to bump progress toward vaginal delivery	*I think most midwives, even if it hasn't been pre-established, we can establish a relationship with people pretty quickly by being present, addressing issues and concerns of women. But for me, it's having that relationship, building up that relationship, so that way, when it comes time to giving birth, being open and exposed and trusting, it's easier, so I think that helps facilitate the birth process.* Irene, section 29	Initial text code was **creating relationship with patient through spending time**. This code addresses the text referring to "establish relationship…by being present". The presence refers to the nurse-midwife spending time at the patient's beside talking and just being around. This opens up the opportunity to establish a level of comfort between the provider and the patient. This is the foundation for the patient becoming comfortable enough to move beyond "niceties of talk" and get into discussions that reveal her feelings, wants, and desires for her birth experience. This transition involves the patient becoming "open, exposed and trusting" of the nurse-midwife and that the care she will provide will align with the patients wants and desires. As coding continued, the initial code morphed into **creating relationship with patient through**

					communication. This new code continued to be supported by this passage, as the nurse-midwife in this passage uses communication to create the relationship with her patient. With the elevation of coding to a theoretical level, this section is an example of the first step in the process of Shaping Birth which is **Connecting**. This section reflects the nurse-midwife forming a relationship with the patient as her initial step in her management of labor and birth. This relationship sets the stage for the nurse-midwife to achieve the other steps in Shaping Birth and "facilitate the birth process."

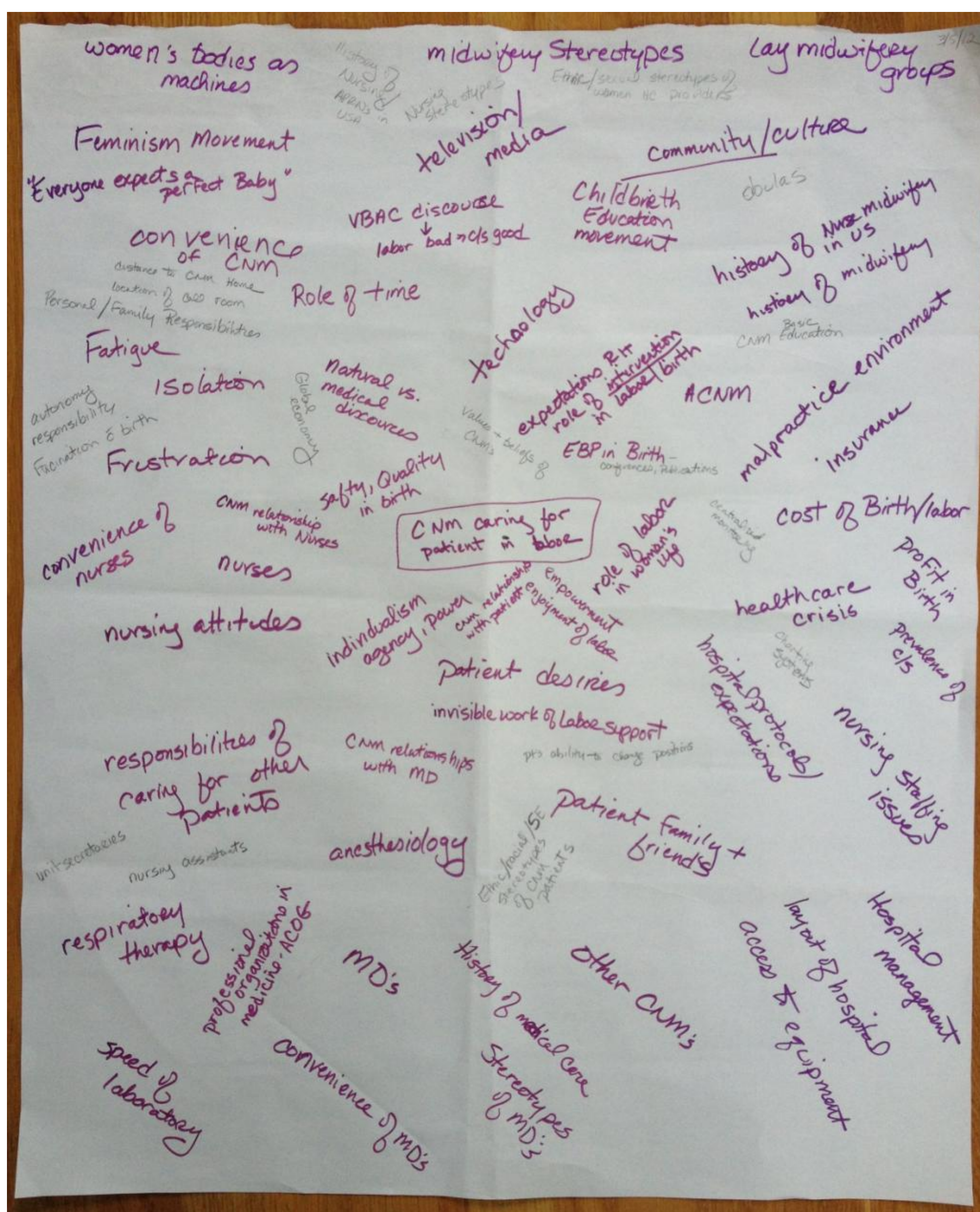


Figure 3: Image of Actual Messy Working Map

Research Integrity, Reflexivity and Difficulties

At the beginning of the analysis process, I started with a question: What are nurse-midwives doing as they manage care in a hospital based labor and birth experience? This primary question informed my choice of interview questions and my initial analysis. I focused on the use of oxytocin, epidurals and cesareans as a way of

analyzing the use of EBPs by these providers. In the first several interviews, I aimed broadly. I asked information about what drew the nurse-midwife to this profession and then asked more specific questions, such as: "Under what conditions would you consider ordering oxytocin for a patient?" The values and beliefs of the nurse-midwives became evident quickly. These providers often used terms like *medical management*, *natural labor,* and *interventive*. The context in which these terms were placed provided insights into the basis for the decision making around the process the nurse-midwives employed related to these aspects of their care. As the analysis continued, I wrote many memos and used these to reflect back on prior analytical choices as a way of confirming agreement with the additional interviews obtained as the process advanced.

I discovered that interview questions that focused on specific interventions often lead to general information. The study participants would say things like "if we use it (oxytocin) and the baby reacts negatively, then we just turn it off, so I don't think there is a lot of thought that goes into turning it on. Because we know we can take it away" (Beth, section 178). Statements like these do not provide insight into the decision-making that occurs when the nurse-midwife gives a specific order for oxytocin. This statement, however, does provide insight into the attitude of the nurse-midwife toward the use of this intervention. The nurse-midwife is prioritizing her ability to control the labor process. She talks about intervention being easy to start and easy to remove, without long-term consequences. This focus does not take into consideration, that she is not using other processes, such as ambulation, positioning, or rupturing membranes, which may be less effective at achieving positive labor progress at a later time in the labor process.

As the research study advanced, I evaluated the data for moments when it would provide greater insight about specific decision-making moments related to evidence based intervention. I discovered that when I asked about a specific birth, either their favorite or least favorite, typically the data would be very rich and detailed. The nurse-midwife would often talk for several minutes without needing additional prompts and she would spontaneously offer specific details about what she was thinking about during her management of labor.

Can you tell me about one of your favorite births?

*…I had never met this patient. I walked in, and she was great, very calm, but she would do her breathing and everything when she had her contractions, she would be very calm and with it totally conversational to me. So we kind of established this nice little rapport and after a few minutes I said, well, why don't I just kind of see where you're at because she'd been in labor, I had heard about her being in labor like early that morning, and here it was … it was midnight, so she had been labor for at least 12 hours…So I said, let's just see where you're at. And she was complete, she was very relaxed and doing a beautiful job with her contractions, beautiful, and she was high (*the baby's head was not engaged in pelvis*) so I couldn't break her water at that point to kind of help her finish off. So I said, well, we'll leave everything be and let me get your antibiotics and as soon as she had her antibiotics, I said, well, what do you think about this birthing stool thing over here? What do you think about that?... So I brought it in and I demonstrated it. She said yeah, that*

looks perfect, that's exactly what I was actually kind of imagining because I didn't know if she had been introduced to the birthing stool before, and she's like yeah, that's great. So I got it all set up for her and she got on that, and so she labored for a while, I think we were still waiting for the antibiotics to go in, actually, at that time. And then as soon as the antibiotics were done, I came back in again and I said, well, what do you think? Do you want me to break your water and just kind of encourage the baby at this point to just come on? And she said, oh, yeah, that would be just fine. And they had been at this since, I don't know, early in the morning and they're ready. And I didn't know the gender of their baby, either, that was like a fun thing, too. I really was looking forward to meeting this baby myself. And she was really conversational in between contractions, so I was really enjoying being in there and getting to know them and we were building a really nice rapport with each other and it was fun. And so I did, I broke her water and beautiful clear fluid, everything great, and so I sat there with her for a few more minutes to see if she immediately got pushy. And a little bit, like a little bit pushy. So I said why don't you, I think it's been a little while since you've been to the bathroom to empty your bladder. Why don't you go walk? That's always my last little trick is get them up, ambulate to the bathroom, empty their bladder, and then they're ready to go. So sure enough like on her way back from the bathroom, she was like "I feel like I need to poop." "Yep, that's telling you, you need to push, honey, that's the baby. Come on and

get back on the birthing stool here and see what your body is willing to do." And I mean, it was like maybe 15 more minutes of really great like listening to her body pushing and me and nurse were just encouraging here, not like push, but just like yeah, you're doing great, good, good, keep going, all that stuff... And it was great, it was just a beautiful, beautiful delivery. (Dorothy, section 80-82)

Dorothy gave very specific reasons for her choice around using the intervention to break the patient's amniotic fluid bag. The choice to "break the bag" is a decision about speeding up labor or assisting in the descent of the baby to facilitate birth. This intervention is used often right along with oxytocin, as the goal of both interventions are similar. The intervention was discussed as a mechanism to "help her finish off," but the choice was not the use of the medication oxytocin, but instead, sitting her upright until the head descended low enough that she could rupture the bag of waters safely. (If the head is too high, breaking the bag of waters, may allow for the umbilical cord to get below the head, resulting in complications) Rupturing the bag of water also allowed the nurse-midwife to assess the color of the amniotic fluid, which may require additional intervention if meconium is present in the fluid. Through the analysis of this section of data, several values and beliefs of the nurse-midwife come to light. Early in the excerpt, the nurse-midwife focuses on how she spent the time to "establish a nice little rapport" before she physically evaluated the patient's labor process. This revealed the nurse-midwife prioritizing creating a relationship with patient over her provision of physical care. Concurrently with creating rapport, the nurse-midwife was evaluating the patient's control and stage of labor based upon her physical appearance and knowledge of the

patient's reported labor process, throughout this initial relationship building exchange, but she waited to evaluate her cervical dilatation until after she had developed a rapport with the patient. "*And she was complete, she was very relaxed and doing a beautiful job with her contractions.*" The use of the terminology "beautiful" as embedded in this descriptive sentence reveals the interaction between the nurse-midwife's focus on helping the woman's labor process proceed toward birth but also assisting the woman in achieving a good birth experience. When the nurse-midwife takes the time to use descriptive words reflective of the patient's experience, her values of supporting a patient's happiness in birth are revealed.

A preliminary rendering of the qualitative results were offered to the last 5 participants at the conclusion of their interviews. These discussions focused on the preliminary findings and further supported research integrity, as a process of checking that the participants are able to connect the results to their personal experience. These discussions were also audio recorded for reference during the final analysis. During the discussions, follow-up questions were asked to elicit details as to whether the preliminary findings were congruent with the practice of the participants. These discussions were then analyzed and coded. This information, in consultation with the members of my dissertation committee, was used to re-evaluate conclusions drawn from the data. A determination was then made as to whether the outcomes should be re-contextualized. Any areas of incongruence are specified in Chapter 4 and the reasoning behind the determination of the final model will be presented (Miles & Huberman, 1994). An audit trail was documented throughout analysis to assess the trustworthiness of the data. The audit trail included documentation of the data, methods used, decisions made with

justifications and the end products of the analysis (Charmaz, 2006, 2009a; Maietta, 2009b; Miles & Huberman, 1994; Schreiber & Stern, 2001).

Theoretical sensitivity.

I tried to cultivate theoretical sensitivity as a mechanism to support research integrity in the data collection and analysis by using memos to acknowledge and document preconceived thoughts concerning outcomes for later comparison against codes and clusters (Schreiber & Stern, 2001). This process starts with the recognition and explication of my experience and personal pre-conceived theories, through memos, as to what is going on (see Table 5). Then, through a process of constant comparison, I constantly challenged the emerging theories, all the while remaining open to a variety of other explanations. Theoretical sensitivity developed throughout the process, as I gathered more specific information. My 'preunderstanding' of this topic allowed me to go deeper into the data, looking for connections which were either supported or not supported as data collection and analysis continued (Artinian, Giske, & Cone, 2009). I maintained detailed memos throughout the entire process to allow myself to think about each analytic decision. My goal was to determine that each aspect of the emerging theory was well supported by the data, and that I was not overlooking alternatives because of personal values and beliefs. I also participated in discussions of this process with my committee and involved outside readers in these discussions with the goal of stepping back and taking a fresh look at the data.

Table: 5: Selected excerpts from my pre-understanding of nurse-midwifery practice

Personal History	Educated as nurse with BSN in 1990, then as nurse-midwife with MN in 1994, practiced in solo private practice for 6 years, first nurse-midwife at inner city

	hospital, then I became faculty at a state university teaching master's level nurse-midwifery. In 2000, I returned to private practice with 2 CNM partners, 6 MDs and 3 NP where I worked for 7 years before beginning my doctoral education.
Experience with intervention in birth	Practiced continuous bedside support, used interventions in birth, ordered oxytocin induction and augmentation (protocols did not require consultation), ordered all pain management methods (protocols did not require consultation), requested cesareans for breech, failure to progress and/or descend in labor (MD would request status and history of my care, but often would proceed with surgical birth)
Philosophy	Patients have the right to choose the pain management options which are best for them, as long as their status remains stable. Needed interventions are appropriate. Non-intervention in birth can be accomplished in the hospital.
Anticipated outcome	Physicians would have significant impact upon the ability of the nurse-midwife to provide care. Nurse-midwives are using interventions and often these may be in situations that are not-supportive of EBP. Nurse-midwives' values and beliefs are no longer focused on normality and exclusive non-intervention in labor.

Difficulties.

I participated in several discussions, throughout this analysis that focused upon recognizing my preconceived thoughts and moving beyond these. I found myself struggling with the goal of nurse-midwifery care early in the research. In an analysis memo, dated 7/19/2011, I noted that the goal of care seemed to be a promotion of vaginal delivery instead of a low intervention or physiologic birth. I memoed if physiologic birth was almost an unrealistic dream in the current health care system. My personal experience with birth management was very different. I worked within a practice in

which labor support was prioritized and discovering that this was not universal, was insightful and highlighted the variation that is present in current nurse-midwifery practice. After discussions with committee members and other doctoral students, I was able to recognize preconceived ideas and refocus my approach toward the data analysis with the added insight of understanding that this study is revealing a window into varied practice of nurse-midwifery.

Nurse-midwives fulfill multiple roles in the provision of care to women and families. These include practitioner, educator, counselor, advisor, friend, advocate, and researcher (S. J. Jones, 2000). I fulfilled these roles as a practicing nurse-midwife for 13 years. However, currently, I am in the midst of a role transition, a move from clinician to scholar. With this transition, I am learning to shed all the other roles and only work from the standpoint of a researcher, in order to recognize differences between my identity and those of my participants. These roles are not necessarily easy to shed, but engaging in doctoral education, with course-work in ethics, research methodology, and analysis, combined with the experience of interacting and working with nurse scientists, I am learning the skills required by my new profession, and how and when to let go of the others.

The roles of educator, counselor, advisor, friend, advocate and colleague can very easily complicate the role of researcher. As a member of the culture that I am studying, my own subjective experience complicates the conduct of this research. The conscious and unconscious desire to portray the profession from a biased viewpoint may complicate data collection, analysis and reporting. I must be very cognizant of my responsibility to the creation of new knowledge, the profession of nurse researchers, and my participants.

These responsibilities require that I remain ethically honest and theoretically sensitive to the emergence of theory from my data. Using techniques of memoing, discussion with my dissertation committee, and constant comparison, I sought to gain an understanding of what is currently happening, knowing that my experience is itself, reflective of a different time period. I am not currently practicing full-scope nurse-midwifery at the time of this writing, thus, technically, I would no longer have been eligible to be a participant in this study.

This distinct difference between the participants and myself enabled me to step from my own experience and listen deeply to the different experiences of my participants. The interviews were grounded in current practice. One benefit of studying practitioners, whose training I share, is that my participants may not have felt the need to protect their profession to an outsider. They may have been able to be more honest and open about the factors influencing their practice.

As a member of the profession for over a decade, I have also gained the understanding that changes in beliefs and practice do occur. I also recognize that my research will portray only one moment in the history of the nurse-midwifery profession. Thus, through this methodology, the outcome can be viewed as a snapshot of reality which can be used by nurse-midwives to step into the quality and safety arena, embracing their role, not exclusively as care providers but also care improvers.

Limitations

Constructionist grounded theory is a method of research in which the participants and the researcher construct the outcome. The resultant theory is anchored in time, place, culture and situation and is reflective of the participants and researcher (Charmaz, 2006).

This theory does not attempt to represent the process of care of all nurse-midwives in clinical practice in the US hospital system. This theory is proposed to provide insight to the actions of 19 nurse-midwives while they provide clinical care during labor and birth in hospitals in the southeastern United States. While, the newly developed theory only describes what these nurse-midwives were doing at the time of the interviews, it still may be used by other practitioners to find resonance with this process in their daily practice and potentially learn from these insights. The process of creating the theory is one of seeing possibilities, establishing connections, and asking questions. Inevitably, these are linked to the researcher's values. The researcher must take a reflexive stance, recognizing when their own values are present in the outcome. As a researcher using this methodology, I must recognize that the current theory emerged from this specific data and multiple realities do exist. Repeating this exact research with the same participants at a different time in their lives, may lead to a different outcome. Within this theory, the facts that emerged and the values of the participants and researcher are linked. Values and beliefs are embedded in the habitus of both the researcher and the participants and these directly influence the statements and claims that are made. The outcome and truth embedded in this research is provisional and evolving. Additional studies into this area with different people and at a different time will lead to new insights that are able to support or negate the claims embedded in this theory. The outcome of this methodology is a theory of a process, and processes involving people are always social in context. This means that every person that we interact with, will and does, have an impact upon our world view and can change how we interact with others. With these changes, the

theorized process will also change over time and will either continue to be supported or additional insights will be found.

The limitations also include several specific qualifications. Subjects may want to portray expected cultural beliefs instead of personal beliefs knowing that they are being asked about their care management styles in the interview. This was a significant concern, as the philosophy statement of the ACNM is widely know and purports a structured belief statement. Discourse analysis used during coding of the values and beliefs was one of the mechanisms I implemented to expose the differences between these published professional beliefs and the personal practice beliefs of these participants. However, this desire to align oneself with professional values and not discuss situations when personal professional values do not align with the professional values remains a significant concern with this analysis. This study focuses on a small, heterogeneous sample (in terms of practice size, location, and patient populations) of nurse-midwives providing delivery services in the hospital setting. Future work may need to limit samples to homogenous populations and outcomes may need to be "localized" prior to the creation of specific interventions to improve behavior (Lamb, 2009).

Credibility

Qualitative research explores complex phenomena and processes. In order to use the outcome of qualitative research appropriately, a scholar must gain an understanding of the process used to determine the outcome. Charmaz (2006) proposes that constructionist grounded theory is judged based upon credibility, originality, resonance, and usefulness. As the researcher responsible for this study, I sought to meet the criteria for these areas.

To verify credibility, I wanted to achieve intimate familiarity with the topic which occurred through the interview process. I determined that the data was sufficient to make the claims when I started hearing the same information repeatedly from the participants. I began to suspect saturation after completing and coding twelve interviews. However, I continued to do additional interviews and verify that no new information or insights into the theory would be obtained through additional interviews. This process continued through the completion of all 19 interviews. With the situational analysis, my data varied from interviews, to various forms of media and lay literature, to medical literature and professional experience. As the grounded theory evolved from the interview data, I then expanded into a very wide reaching analysis of the field of practice. After reaching saturation with a wide view of the environment of care, I then focused my situational analysis inward on the factors with the most significant impact upon the new theory.

To verify originality, I sought to answer new questions with my theory: what is the process of nurse-midwifery care? This theory approaches nurse-midwifery practice from a new angle. I focused on the actions of what nurse-midwives do when they provide care. My goal was to create a new conceptual view of the practice of nurse-midwives, to gain understanding of how they are able to achieve their documented positive outcomes, yet practice within the context of healthcare system that seems to support routine use of interventions. This opens a new insight into the provision of obstetric care by nurse-midwives. The people under analysis were nurse-midwives currently providing care in the hospital system. The details of this study are unique in that for the first time, the voices of practicing nurse-midwives are present in the final model of practice.

To fulfill the requirements of resonance, I sought to verify that the outcome represented variety within nurse-midwifery practice. I reached out to nurse-midwives practicing in different hospital and practice environments. I sought to understand the breadth and depth of the practice environment and the variety that is present when people provide care to other people. I discussed the outcomes of this study with the last five nurse-midwives that were interviewed and with the members of my dissertation committee that have experience with or professional backgrounds in nurse-midwifery. The feedback was that they understood and could picture themselves acting in the same manner as the proposed process when they provide care. They were able to describe specific situations when the model was an accurate representation of what they do when they manage patients.

> *(Labor is) a normal, natural process and I'm going to be there with her through all of it, at least to some extent. And I'm going to try to tell her and provide to her all the information that I have or that I know to help her understand the process so that she feels like she's a key player and not just, didn't just present herself and let somebody else call all the shots… We're going to tell it like it is. We're just straightforward and honest. Sometimes they don't want to know it. And we try to find a delicate way to bring them around to knowing it the way they need to know it… I feel like we've done, I've really done a lot of what I needed to do to help them accomplish something that's very important. I have one lady that I see on occasion that had hypertension. Her baby is a year old. And she wanted this baby out at 36 weeks. She didn't want to take her blood pressure and*

> *stuff. She always thinks – she didn't want to lie down, she still wanted to go to work, even though her blood pressure was off the roof. She told me the other night you guys helped me through it. You guys did your job well. You guys gave me a healthy baby and helped keep me healthy.* (Pam, section 166-174)

The final criteria for evaluating grounded theory research is usefulness and whether the new theory is able to offer interpretations that people are able to use in their everyday lives. My hope is that nurse-midwives will be able to see themselves in the new theory and that this insight will give them the self-awareness that allows them to embark upon changes that further support the use of EBP's in labor and birth management. While my participants noted resonance, the real test of this theory will be if other nurse-midwives and/or other obstetric providers may find insights via this theory into approaches that might allow them to motivate changes that can result in improvements in healthcare quality and safety. Any process of quality improvement must start with an acknowledgment of where you are and where you want to be (Ransom, Joshi, Nash, & Ransom, 2008). With the understanding of how nurse-midwives in this study provide care, then others are able to look for similarities and differences in their own practice of obstetrics. It is my hope that this will open up instances of dialogue and further research that will stimulate improving obstetric care for women and their babies.

Chapter 4: Process and Outcomes

Overview of *Shaping Birth*: The Nurse-Midwifery Process of Care

This analysis focuses on decoding the inner workings of a process: what happens when a nurse-midwife is working with a patient in labor. This answer is not straight forward. Nurse-midwives do not practice in isolation, nor do they all practice the same. They function within an environment that affects and shapes the care that they provide. The layers of this environment are multifaceted and deep. This environment is not just physical; it also includes the people with whom they interact and the emotional and mental history that the nurse-midwife carries with her to this experience. All of her knowledge, her skills, and her previous experiences, shape her value and belief system which in turn, forms the foundation for her actions.

The space in which the theorized CNM works has at its center the human female body. The moment of my analysis is when this body, containing two human entities, is in the process of becoming two separate discrete beings. My focus is on a theorized nurse-midwife's management of this process, starting with one human enveloping another and ending with the physical separation of these two individuals. Her attention is not solely focused on the physical support required, but also on the emotional and mental support. The change her patient is undergoing is not exclusively physical, but also emotional and mental. The theorized CNM is there to support that change in a way that will allow the childbearing woman to embrace this transition. The theorized CNM uses a specific process of care to accomplish these tasks, thus *shaping birth*. She must actively connect, protect, and intervene in order to support the outcome of achieving a healthy vaginal birth via a progressive labor, resulting in a labor experience that the patient defines as *good*.

In the next chapter, I will start with a discussion of the participants' values and their beliefs related to nurse-midwifery care. Then, I will move into a discussion of the environment of the participants' nurse-midwifery care. Finally, I will conclude this chapter by presenting the theory of *Shaping Birth: the Nurse-Midwifery Process of Care*.

Cultural Analysis of the Work World of Nurse-Midwives

Habitus of nurse-midwives.

The habitus is a "system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a *matrix of perceptions, appreciations, and actions* and makes possible the achievement of infinitely diversified tasks…" (Bourdieu, 1977, pp. 82-83). The habitus is the sum of an individual's history, experiences, values, beliefs, traditions, customs and principles (Bourdieu, 1977, 1990). To describe the habitus of nurse-midwives, I first undertook a process of analyzing the history of nurse-midwifery, focusing on moments which shaped practice. I concluded this process with a discourse analysis of the interviews of the participants, concentrating on their values and beliefs related to the care they provide to patients during labor and birth.

History of nurse-midwifery, as embedded in a nurse-midwife's habitus.

This history of nurse-midwifery in the United States has a profound effect on the current role of nurse-midwives in our health care system. Public conceptions of midwives have been associated with ignorance and poverty (Declercq, 1994; Rooks, 1997). Many nurse-midwives currently spend a significant part of their initial interactions with patients and providers explaining who they are professionally because many of these perceptions still persist today. Only recently has this started to change and

nurse-midwifery has become publically recognized as an advanced practice provider. Currently, nurse-midwives are known as mid-level providers and, with limited exceptions in a few states, the profession remains dependent upon physician authority to practice. To understand the depth of stigmatization that current nurse-midwifery care is influenced by, a brief analysis of the history of midwifery will provide the details.

In 1910, over 50% of all births in the United States were attended by midwives in the home and midwives began to be recognized as competition by the medical profession (Rooks, 1997). It was believed that if you could get the mother as your patient, then she would bring her family back to you for their health care. Nurse-midwives often used natural medicine and worked with women to encourage the physiology of birth through movement and herbs. This alignment with natural processes, was demonstrated through their use of common cooking ingredients and herbs in their provision of health care (Gibboney, 1978). Professional medical organizations began sponsoring newspaper advertisements and social campaigns attributing the high rates of morbidity and mortality to the midwife rather than the unsanitary and crowed living conditions of urban America (Devitt, 1979a, 1979b; McCool & McCool, 1989). These stories characterized midwives as dirty, poor, ignorant women who delivered babies in people's homes. Gradually as a result of these public education campaigns by organized medicine, societal viewpoints began to shift. As a result, midwives gradually lost favor as they were seen as the undesired providers for the poor, with dirty bare feet and old knowledge. Physicians were seen as the deserving providers for the middle and upper class society as a result of their high quality university education (Devitt, 1979a). By 1930, obstetrics became an established medical specialty within medical education (Thoms, 1960). Medical science

terminology began to dominate descriptions of labor and birth as doctors became known as 'men of science' (Ehrenreich & English, 1970). This shift in delivery providers was not associated with improvements in obstetric outcomes. Wherever the numbers of midwifery providers declined, maternal morbidity and infant deaths from birth injuries increased (Rooks, 1997). After making midwifery illegal, the maternal mortality rate in Massachusetts increased from 4.7% in 1907 to 7.4% in 1920 and infant deaths throughout the U.S. rose 44% between 1918 and 1925 (Devitt, 1979a, 1979b; Rooks, 1997).

This shift in public perception, from the ideal provider of care to the undesired provider of care, shaped nurse-midwifery in profound ways. During this time period, nurse-midwives had to become rebels, functioning outside of mainstream obstetrics to continue to exist. The profession persisted through the creation of pockets of midwifery. These midwives did provide care to the poor and indigent, but they also stayed responsive to the needs of their patients, providing care to entire families and communities. Within these locales, the midwives were respected, but functioned outside mainstream medicine. Nurse-midwives of today still need to explain their role and scope of practice, because the images of this period in history, especially in the area where this study takes place, remains ingrained in the minds of potential patients and their families.

Over the latter half of the 20th century, nurse-midwifery continued to evolve outside of the hospital system. In the rural south of the 1930's, Mary Breckenridge brought British educated nurse-midwives to the United States and formed the Frontier Nursing Service, in order to provide care and safety education to lay midwives (Breckinridge, 1981). As nurse-midwives were pulled into private health care to meet the needs of women not being addressed by the health

care system of the 1960's and 1970's, nurse-midwifery practice expanded into mainstream health care and moved into the hospital for births, providing prenatal, intrapartum, postpartum care and newborn care up to the first year of age. Nurse-midwives, during this time, formed collaborative relationships with physicians and obtained hospital privileges in order to work in the locations where birth was occurring. "I think over the years we've proven that we deliver the babies, we practice safely, so all of that is our history" (Rachel, section 106).

During this same time, the hospital environment moved from being a place for the long term treatment of chronic illness to a place currently of stabilizing illness and injury with acute treatments. This shift has also resulted in significant philosophical changes related to how care is provided. Chronic illness requires in depth education and self management while acute treatment is organized by cure via specific medical interventions. This shift in focus permeates care throughout the hospital, and obstetrics is not exempt. The liberal feminist movement of the 1960s sought changes in obstetrics by advocating for increased education of women through childbirth classes. The feminists believed if women had more knowledge, then they would have the power to influence the outcomes of their own births. However, most women never obtained this power via knowledge; instead they assumed responsibility and the blame for their own non-ideal birth outcomes, never realizing that their choices during birth were already controlled by society and the institution of the hospital (Bogdan-Lovis, 1997). Acute intervention in the management of birth is now the norm and cesarean section has become the most performed surgery in the United States (Levit et al., 2009). Currently, cesareans occur in 32.8% of all live births in the U.S. (J. Martin et al., 2012).

The shifting of these beliefs is evident in the language that permeates birth. This language emerged during the time medical management assumed the power in the management of obstetrics and continues to be used today. Many terms are used in obstetrics with the result of distancing care delivery from recognition that the object of care is a person. These terms may include fetus, perinatal mortality rate, parturition, induction (and/or calling women by the procedures they are undergoing), vaginal examinations, cervical checks, fetal surveillance, among others. Nurse-midwives also incorporate these terms into their language use along with terms such as mother, baby, tummy, breast; but the degree to which different terms are embedded in their language, demonstrates their alignment with their values and beliefs.

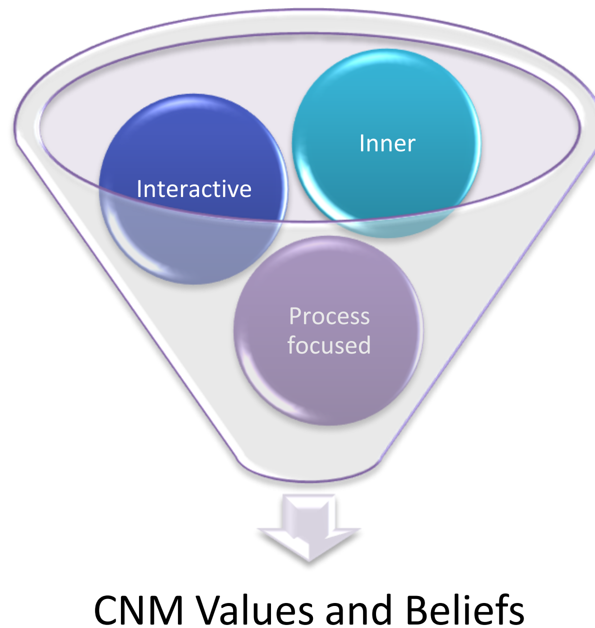


Figure 4: Values and Beliefs of Currently Practicing Nurse-Midwives

Values and beliefs of practicing nurse-midwives.

Many of the reasons that bring nurse-midwives to their chosen profession actually affect the care they provide in an on-going manner. Bourdieu connects the habitus of the individual with their outward actions. Nurse-midwives habitus, or embodied reality, evolves from the factors that influenced the creation of their reality. The reasons why a nurse-midwife enters the profession has an impact upon what she does and the personal rewards she receives from providing nurse-midwifery care. As part of the opening questions of the interview, I specifically asked why they decided to become a nurse-midwife. Typically, nurse-midwives are very comfortable answering this question, as it comes up many times in their lives: during their education, during job interviews and frequently during their initial interactions with their patients. As such, this reply may be

rote, but my specific desire was not solely the details of the answer. I was also interested in their word choice, as they described their reasons. The words used by the nurse-midwives were insightful, as they revealed specific values and beliefs.

Nurse-midwives, who were interviewed for this study, spoke of several reasons why they decided to enter the profession of nurse-midwifery. These reasons were categorized as either inner beliefs, interactive beliefs or process-focused beliefs.

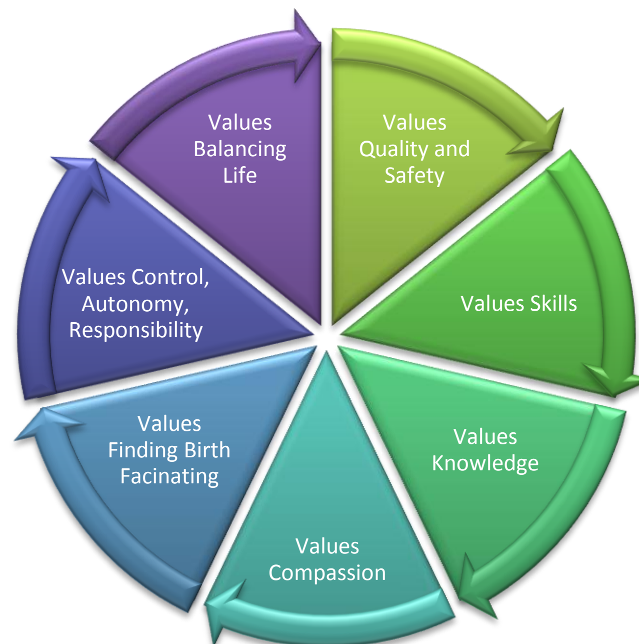


Figure 5: Inner Values and Beliefs

Inner beliefs.

Inner beliefs asserted by nurse-midwives include a focus on valuing quality and safety in birth, valuing skills and knowledge, valuing autonomy, and responsibility, balancing office hours, call time, and personal life and valuing a fascination in the birth process evolving out of an intrinsic compassionate quality.

> *"Obviously, the highest expectation is expertise in your craft. And safety. Those are fundamental. And once you have that groundwork, that's basically everybody's expectation, be safe, be very good at what you do, very knowledgeable, and then the third thing is, everybody expects good communication."* (Nancy, sections 13-14)

Nancy begins the discussion of the expectations of her care, with describing what she does as a 'craft.' This is a different grounding for this discussion, than how you would expect a lawyer or doctor to refer to their practice. Using the word craft in this intertextual context brings up visual images of creating things by hand and often these things are beautiful or decorative. With the use of this word, Nancy grounds this entire discussion by showing her love of the work she does. Nancy stresses that "expertise" and "safety" are fundamental to the practice. The linkages between expertise, safety and craft exhibit the connections between the art of practice and the expertise of practice. These connections occur within the same sentence demonstrating how closely this nurse-midwife connects these ideas within her mind. This is an example of dual voices being present in the same segment of text: the voice of the artist and the voice of the medical provider. This intertextuality reveals the nurse-midwife's dual self-identification.

> *(When) I unexpectedly became pregnant with my second child…I started reading everything I could about pregnancy, since it had been 14 years since I had a baby and (that is when I) learned about nurse-midwifery for the first time… When I read about nurse midwives and what midwives do; it was literally like an epiphany. I just felt like oh, my gosh, that is what I'm supposed to be doing. And I've been doing the wrong thing all these*

> *years…the call of midwifery was there. I just couldn't shake it. For probably a year after that, I thought, no, no, that's just ridiculous. I can't start all over again and go to nursing school. I was never interested in being a nurse. It held no appeal for me. I think because I always, and I'm talking about growing up, I always saw a nurse as kind of a subservient doctor's handmaiden kind of position and it was never anything interesting to me until I found out about midwifery. And so to make a long story short, after my daughter was born, I taught a little while, I continued to take classes, but I just could not shake the midwifery thing. And so I went home one day and I told my husband, honey, I'm sorry, but…I'm starting all over again and I'm going to go to nursing school and become a midwife.* (Tammy, Section 2)

The inner beliefs also involve the nurse-midwife prioritizing compassion, responsibility, autonomy, knowledge, and skills. These include a focus on maintaining the quality and safety of birth and maintaining a sense of fascination in the birth process. The sense of fascination in the birth process was a dominant thread throughout each nurse-midwife's discussion. This harkens back to the history of midwifery, when midwives spoke of a "calling" to enter the profession of midwifery. This is again another example of intertextuality revealing a dual self-identification. Today, *calling* has evolved into speaking about having a fascination in the birth process. In the previous section, Tammy exhibits this genre chain in her language, demonstrating the evolution of *calling* into a fascination with what nurse-midwives do. This fascination is more than just a

motivator to enter the profession; it remains a value for staying in the profession and motivation for the work of nurse-midwifery.

> *My whole life, I was obsessed with birth. I always thought it was the coolest thing; and my parents got me* The Miracle of Life *video when I was 6. I would just watch the end part over and over when the baby was coming out, cause it was just so cool…So I guess it just kind of developed into more of, you know, just a fascination, (that) this could actually be a profession. I was planning on being a physician initially when I went to college and I always knew that I was interested in women and babies, um, and then when I decided I to be a nurse instead of a doctor, it was really quick transition to when I found out what a midwife was, I was like "oh- that is exactly what I am doing."* (Beth, Section 3)
>
> *As long as I can remember, I've always been interested in mothers and pregnant women and babies,… and I mean like (when I was) eight and nine years old, okay, I always massively attached, I say attracted, but that's a funny word to use, to pregnant people or babies. And then I babysat from a young age, so I found that I can really work well and get babies to sleep and help bring the baby to mom. My family all breastfed and my mom's mom had ten children, so any time one of mom's brothers or sisters had babies, I would go to the house and stay two weeks forever that I can remember. So that was definitely an interest in mother/child interactions of all sorts.* (Frances, Section 4)

Beth and Frances are discussing their fascination with birth. Using descriptive terms such as “obsessed”, “massively attached”, and “attracted”, these nurse-midwives reveal the substantial interest they have for what they do. Beth and Frances are not unique in these descriptions, the other interviews also demonstrate this inner value of fascination as being embedded in the nurse-midwives’ habitus.

Beth and Frances both use the words “mother” and “baby” when referring to the object of their labor management. The uses of these terms in this context reveal a connection to these individuals. They recognize that their patients are human beings and relate their interactions with mothers and babies back to their own experiences in life. This reveals recognition that they see their patients as inherently similar to themselves. This occurs without the use of terms that psychologically distance themselves from the people they provide care to. This section exhibits interdiscursivity where the words used here reveals the practice of these nurse-midwives. Through the use of these words, the nurse-midwives are shifting their roles to that of an equal in these relationships. This connection forms the foundation for the inner value of compassion and the desire for a relationship with patients.

> *It’s just such a miracle. I always was interested in science and that aspect of child birth and pregnancy, and just the process. I just thought it was great. And I just felt like, I don’t know, going through the other rotations, medical rotations and whatnot, I just didn’t feel the same passion for what I was doing nor the same interest. And I guess it was just – and I also felt a closeness with women. I wanted that relationship… I wanted to see the woman throughout the process of pregnancy and then to the end point of*

> *delivery and postpartum and then hopefully see them back again. I guess I just felt this need and desire to sort of extend that relationship. And I found it really satisfying. So the science, as well as like the psychological aspect of it, I think, there's more than just an interest, it's also just that social or psychological aspect that was important to me to kind of be in touch with.* (Lisa, Section 4)

In this section, Lisa expresses her concurrently held values of knowledge, right alongside with her desire to create and maintain a relationship with the women she works with. These values are not prioritized one over the other, but instead viewed as equals in her goals. As Lisa is talking, you can trace her thought process transitioning from her interest in science and the process of birth to the connection with women. She goes on to mention specific aspects of that connection, including social and psychological, that are intrinsic to this closeness. Her use of the word *closeness* is important also. This word reflects not just a physical proximity to her patients, but she also links this closeness to them socially and psychologically. She embeds all three of these aspects into her connection with women. This closeness brings us into the next group of nurse-midwifery values. By highlighting the science and connecting this via genre mixing to psychological support, this nurse-midwife is drawing attention to her view of her role as encompassing both of these aspects.

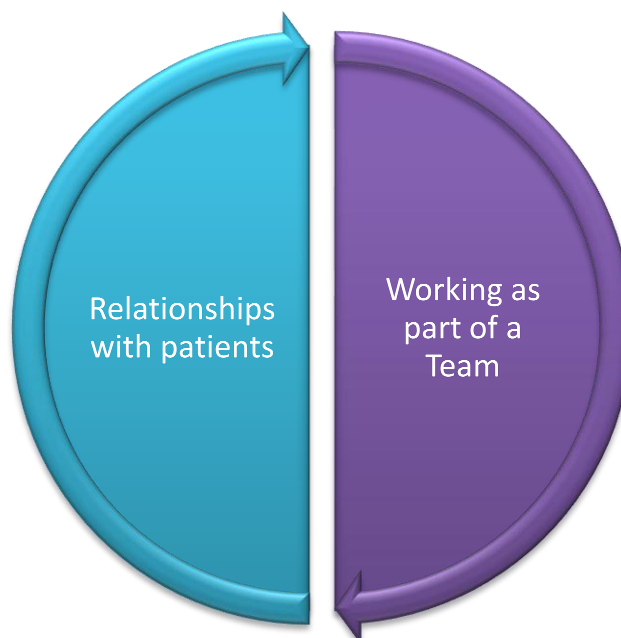


Figure 6: Interactive Values and Beliefs

Interactive beliefs.

The CNMs who participated in this study specifically discussed values related to patient- associated relationships. They described values that included focusing on the totality of the patient, valuing emotional reactions, especially happiness in the birth process, valuing choice in birth, empowering women, and spending time with women.

Looking again at the previous text, Linda is expressing a desire for connection. The connection, once obtained, provides both physical and psychological rewards; in terms of providing satisfaction for doing her job well and maintain professional passion. Linda also highlights the difference between the connections that she is able to achieve as a nurse-midwife from when she was a nurse. By referring to the relationship as "*closeness*," she is focusing on the bond that is formed between her and her patients. The use of this word highlights a distinct difference in this relationship. *Closeness* is typically a component of relationships between people who know each other very well. When

people are close, they share personal information, ideas, wants and desires. A close relationship takes time to develop and nurture and requires both individuals to be willing to share of themselves. In today's very busy society, it is often very difficult to create and be a part of close relationships, yet this nurse-midwife seeks them out as the ideal relationship with her patient. In a close relationship, both participants will connect emotionally and are willing to take the time to really understand the other person's wants and desires. Through this relationship formation, the nurse-midwife is able to appreciate the totality of person, getting to know their personal and family situations. This knowledge can be critical, as the emotional context of the patient does influence the process of birth and the amount of pain experienced in labor (Lowe, 1996).

> *My contract with a patient, I feel like, is very different than her (the physician's) contract with a patient. I feel like I enter into more of a peer relationship with a patient, where I acknowledge that the woman is the expert on her body and I'm the expert on midwifery and we're going to partner together to come up with a plan for her care and that kind of thing. It's a much less authoritarian model than the physician/patient model.* (Tammy, Section 18)

The nurse-midwife also values creating an emotional connection with her patients. "A person tends to experience an immediate emotional response to the face which a contact with others allows him" (Goffman, 1967, p. 6). This emotional connection flows from the close relationship; the closer the relationship, the closer the emotional connection. The nurse-midwife also values empowering women and supporting the choices that they make.

I think one thing that's really important to me is that women realize just how strong they are. I think a lot of women think that they're weak and they can't and they won't; and that you're a powerful woman and there is much within your grasp and within your power that you can do, not only for your birth, but for the rest of your life. (Jill, Section 114)

Jill uses words like "strong" and makes a connection between her patients being powerful women and having much within their grasp. The connection between these clauses exhibits her belief that each woman is able to accomplish the goals they set out for themselves. She sees birth as a metaphor of possibility to the rest of the woman's life. If Jill empowers women during their pregnancy and birth, then she believes that the woman will be able to acknowledge the power she possesses and activate it in other parts of her life; by making a choice and following through to completion. Seventeen of the nurse-midwives interviewed specifically spoke of processes reflective of patient empowerment and how this guides their interactions with patients.

Nurse-midwives also spoke of how they valued working as part of a health care team. They valued creating relationships with both the physicians and nurses that they worked with and that these relationships were critical to their provision of care. The nurse-midwives in this study used a multitude of terms to describe their relationships with physicians: *awesome, wonderful, really nice, good relationship, they know I will call them if there is a problem, good guys, just people like me, excellent back-up, extremely conscientious, they are there when we need them to be there, universally invested in the best outcome for the patient*. Overwhelmingly, the terminology used to describe the physicians that nurse-midwives worked with closely was very positive. The

nurse-midwives that participated in this study were currently employed in very supportive relationships with physicians and while three nurse-midwives mentioned interactions in which the nurse-midwife struggled to get her management plan supported, the nurse-midwives often reflected that these issues revolved around the physician not being aware of information about the CNM's scope of practice (i.e. new residents who had never previously worked with CNMs) or not aware of a specific goal of the CNM. Tammy mentions one of these episodes of different viewpoints below.

> *I just mean when someone's pushing out a baby, she should be the center of attention in the room. There's no, in my mind, there's no room for discussion about television shows or anything else. Your attention should be focused on the mother and on the father, rightfully so. But I think that it (physician being distracted during birth) definitely wasn't malicious or anything else. We have two wonderful physicians. I care about them very deeply. They are wonderful, they're a good fit for our practice, but I think they do surgery so often when the patient is asleep that that's just kind of normal for them, that when they're doing a procedure, they're talking and doing other things at the same time. But it's not normal for me. It just, it seems disrespectful to me for your attention to be able to wander away from her in such a way that you can have conversations about completely irrelevant things at the moment. So I will talk to them about that at some point. But initially, all I did was talk to her about the episiotomy (that the physician did on her patient during delivery)… (The Doctor) brought it up because she saw… the look that (the husband of the patient) gave to you*

> *(CNM). And I said, "yeah, I feel like he thought that I betrayed him." And she said, "Well, why do you feel that way?" And I said "because you didn't tell them that you were going to do it and you didn't ask it if was okay." And (the physician) said, "well, (Tammy), I'm not accustomed to asking someone if I can do something if it's medically necessary." And I said "but (Dr. Physician), people have to consent before we do something, that's doing something without her consent." And (the doctor) said, "well, I didn't think about it that way, I'm sorry."* (Tammy, Section 18)

Despite the different viewpoint mentioned, this exchange is exceptionally collegial. The physician replies in a manner that exhibits their true desire to support the patient in the most effective way she is able to. This exchange also brings to attention the differences between the relationship the nurse-midwife and patient create and that of the physician/patient relationship.

The nurse-midwives talked a great deal about their relationships with the nursing staff in labor and delivery. As the analysis evolved, I discovered how significant the nurses were to the ability of the nurse-midwife to provide evidence based care. The nurses had a huge impact, both positively and negatively. This revelation came as a surprise to me during the analysis. The CNMs described nurses as *friendly, positive, very supportive, on the same page, willing to change/open to doing things differently, awesome, very independent, supportive, kind and compassionate, knowledgeable, I listen to them, we're a tea.* They also described the nurses as *rule orientated, rule enforcers, busy, task oriented, overbearing, Pitocin friendly, not very touchy/feely, comfortable with technology, likes to rush labor, and may yell at patients to push.* These terms were pulled

straight from the transcriptions and exhibit the significant variation in the relationships that nurses and nurse-midwives have. Regardless of the quality of the relationship with individual nurses, the nurse-midwives discussed over and over how much they valued these relationships. To create and sustain relationships with the nursing staff, the nurse-midwives spoke of how they would offer in-services to the staff. When they were on-call, instead of going to the sleep room, they would stay at the nurses' station and talk with the nurses, asking them about their personal lives, their families, and their own goals in life.

> *I think those of us that have a slightly better rapport (with the nurses) hang out at the nurse's station. So we hang out at the nurse's station between births and when we're not real busy and make small talk and just be friendly. Figure out if they have kids or what they do, just generally being friendly.* (Kim, Section 93)

> *The nursing staff? Well, they have a huge influence on what happens in the labor room. I mean, they're the 24/7 provider. They're always there, thankfully. It could be very positive, but it could also – they try to influence your decisions. It happens every day you're on call where you'll have a patient and the nurse will say this patient's never going to make it or I'm no liking this strip and you know they'll throw things around, which is fine. Of course, they need – this is their patient, too. They need to give you their opinions and things. But I don't know, how do you not let someone have some impact or influence on you and someone stating something that they're not comfortable with. Of course you're going to*

take that into consideration. Of course that's going to have some influence probably over a final decision on something. I don't see how it couldn't. (Lisa, Section 104)

The relationships nurse-midwives enter into with physicians and nurses have a significant amount of influence on the care provided by nurse-midwives. At the core of these relationships is give-and-take, in terms of power and the ability to function in a way each individual provider desires. The section on capital and the power of the nurse-midwives explores these negotiations in more detail.

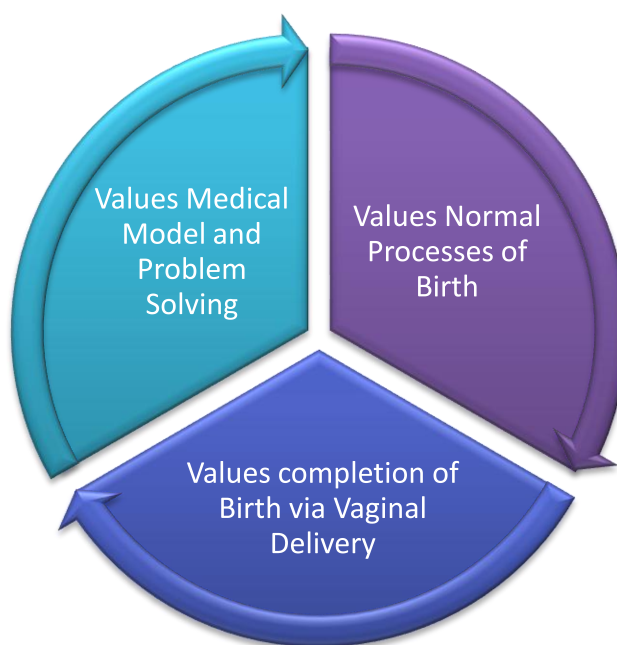


Figure 7: Process focused Values and Beliefs

Process focused beliefs.

The nurse-midwife possesses values and beliefs that are process focused. This includes a belief in normal processes of birth, the completion of birth via a vaginal delivery while concurrently holding a belief in the medical model of care and the problem solving that is associated with the medical model of care. The tenets, which the

participants described as part of a belief in the normal process of birth, include individualized, researched-based appropriate use of technology and intervention and alternative medicine techniques. The participants also talk about placing strong values on completion of birth process, focusing primarily on the vaginal birth route. The nurse-midwife also values her ability to problem solve in labor and values the medical model of birth (however this value may sometimes conflict with her other value of normality and appropriate use of technology and intervention). These values and beliefs form the structure of the nurse-midwife's habitus. On a moment to moment basis, she may not be aware of the influence of these values and beliefs, but they shape her decision making in significant and non-subtle ways.

> *"She was being induced and it wasn't going real well. And I was really thinking this is bad because this is not going to be a (vaginal) delivery. And I knew the time was running out because I knew this doctor, he was one of those that you'd better stay on the Friedman's Curve. I could not get, I didn't know what to do. I couldn't get this girl delivered. And so the nurse that was with me was a midwifery student at (the university)… And we all, I mean, we went to the station and we told the patient, we were just like hang on, we'll be back. We went to the station; we got every nurse from every station and said, okay, what can we do? And one nurse said, well, I've heard if you put an IUPC in and you just amnioinfuse them, that will help them get delivered. Another nurse said I've heard if you put their leg in this position – we did everything that every single person suggested, and the next time we walked in the room she was complete and*

was on the perineum. And this was somebody the doctor was coming in because he was getting ready to take her to the OR. And he walked in, and he had actually delivered her. And she burst into tears and her mother burst into tears and we all burst into tears, and it was just great. And the baby came out, and it was like yay. We were all were just like belly bumping each other because that was, we did – I mean, in a different situation, if the nurse hadn't cared, if nobody had cared, if I hadn't cared, if the nurse hadn't cared, she would have had her heart broken and she would have had a C-section. But we all cared and we were like okay, does anybody know of anything that we can try that we haven't tried? And we did it all, and she delivered. So that was a good delivery." (Nancy, section 20)

These values and beliefs shape social practices and are revealed through orders of discourse. "An order of discourse is a network of social practices in its language aspect." (Fairclough, 2003, p. 24) These discourses shape the language; and through shaping the language used, also shape the social organization and structure of the environment. Nurse-midwives function within a social, hierarchical environment known as the hospital. In this environment, as in any hierarchical community, there is struggle for power which consists of exerting the dominant mode of thought and practice. These struggles take place between all individuals within this environment, but may be seen more often within interactions from individuals who spend more time together or who may be closer together in the hierarchy. These struggles evolve from the exchange of capital between the professionals supporting birth and will be discussed in the next section.

Capital of nurse-midwives.

"I think that that's happened to births in this community, that people come in and they feel like all physicians are out to induce you and to do unnecessary interventions and that's not helpful, that you need to, number one, pick team players. We're all on the same team here. Everybody in women's health wants a good outcome. People do not set out, for the most part, to give you pit because they want to go to the golf course."(Gale, section 76)

Agency, as a term that reflects an individual's use of power, can be used in a myriad of ways. However, it can also be a marker for the exchange of capital during interactions between individuals possessing differing amounts of power in a given situation. Relations of domination evolve out of social relationships. These social relationships must be continually created. The social world allows for the perpetualization of these social relationships, thus freeing up the individuals from the work of maintaining these relationships (Bourdieu, 1977). The hospital environment is a social world. Once the hierarchies of relationships are formed in this world, they are perpetuated by the agents within, unless some component makes a significant change, thus altering the social world. However, a social world also contains "mechanisms capable of reproducing political order independently of any deliberate intervention" (Bourdieu, 1977, p. 189). As the hospital system perpetuates the actions needed to continue the social relationships, they become more and more reinforced by cultural capital.

Interactions with physicians and nurses.

Social institutions create the structure for discourse at all levels (Foucault, 1972, 1978). These social institutions frame how conversations and interactions will take place, what words are appropriate, who can and cannot participate in the discourse, and at what level individual social actors may participate. These same institutions establish the limits of the discourse and what punishments are enforced for those who go outside its boundaries.

Nurse-midwives function within a world composed of three separate practice arenas; each with their own cultural capital. These include nursing, midwifery and obstetrics. Nurse-midwives are educated first as nurses and then as midwives. With this duality, they are part of the range of discourses associated with nursing. Popular discourse about nursing includes the female/male duality between nursing and medicine. Nursing has been viewed historically as a female profession (Ehrenreich & English, 1970) and therefore inferior or subservient to the male profession of medicine (Starr, 1982). On the other hand, popular polls often rank nurses as the most trustworthy profession (J. Jones & Saad, 2012). They exist as protectors: caring, mothering figures in healthcare. This stereotype exists in contrast to the stereotype of physicians, whom hold the highest level of authoritative knowledge but also can be cast as controlling, quick to intervene, and emotionally distant: one who gives orders but does very little hands on care.

The female body is often compared to a machine which our health care system must work towards keeping functioning within normal limits, especially during the process of creating another being (E. Martin, 1987, pp. 54-67). Martin (p. 64) points out

an analogy that is present in medical imagery: a doctor manages work by the laborer (the woman is compared to a field worker) and the machine (the uterus) in order to achieve the product (the baby). She then goes on to note that the procedure requiring the most management by the physician and the least work by the woman and her uterus, the cesarean, has been portrayed as providing the best products by avoiding the infant's exposure to the trauma of labor. These manufacturing images are reinforced by the terminology we use in society in reference to women. Examples include house cleaning being called "women's work", working outside the home, often in upper management is "a man's job" and giving birth to a baby is called "labor". The male doctor has an active, positive role embodying the culturally higher role in society and the woman patient has a passive, laborer role, aligned with a culturally lower role in society. In this manner, stereotypes are further reinforced (Ortner, 1974). When we add in nurse-midwives and nurses to this mix, (both professions remain predominantly female), this imagery reinforces the devaluation and subjugation of these roles to that of the medical profession which is stereotyped as predominantly male.

CNMs have to contend with their own stereotypes. One view is that all midwives are barefoot, dirty, uneducated purveyors of home birth, another casts the midwife as ideologues of "natural" birth forcing women to experience the pain of childbirth and preventing them from having any assistance from modern technology. These discourses often overlap with medical discourses of CNM's as advanced practice registered nurses embedded broadly into the current medical community, embodying current values and beliefs in medical intervention.

Nurse-Midwifery, as a profession, must successfully incorporate what is useful about these stereotypes, and resist what is not, in order to effectively care for their patients. Nurse-midwives often find themselves doing substantial patient education in order to dismantle the stereotypes and present a more complex, nuanced, and contemporary view. By spending the extra time doing the basic patient education about who they are and what their role is in health care, nurse-midwives are taking the first step towards connecting with patients at their level. The extra moments spent educating patients about who nurse-midwives are, must be presented in a way the patient understands, using terminology that the patient understands. In this way, the nurse-midwife is positioning herself at the level of the patient as an equal. Doing this, the nurse-midwife is starting a health care relationship at a level that can result in personal growth for the patient.

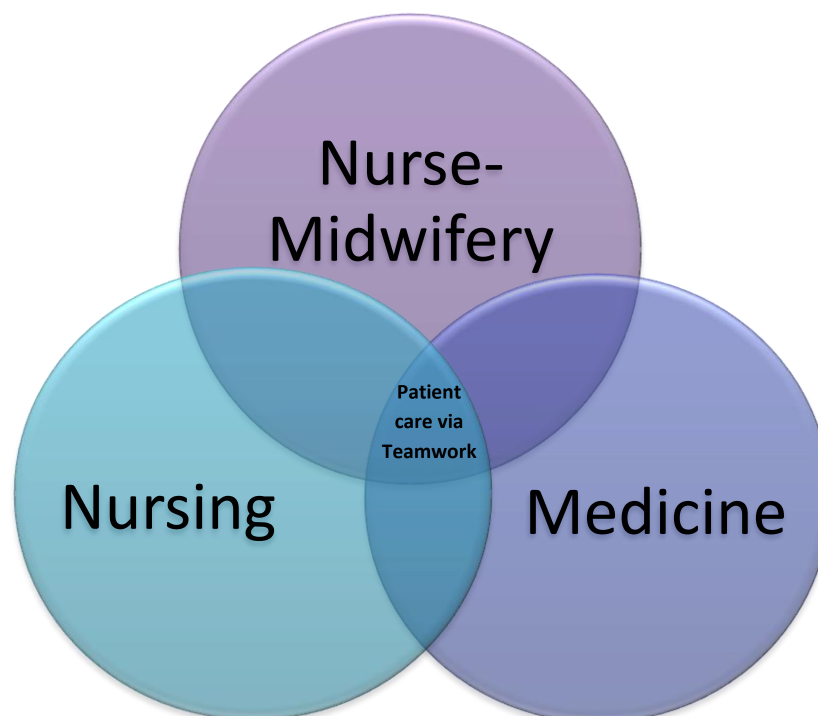


Figure 8: The Three Worlds of Medicine, Nursing, and Nurse-Midwifery intersect to form the Central Domain where Patient Care is Provided via Teamwork

Physicians possess significant social capital in the hospital, as they often maintain multiple positions of power both within their own practices (they may be owners, managers or CEOs) and within the hospital itself (leading clinical and administrative committees that shape the provision of care). In labor and delivery, the nurse possesses a significant amount of control. The nurse is the 24/7 care provider and the expert in hospital rules and regulations. The nurse often functions on committees that create and evaluate the use of new procedures in the hospital and maintains a dual role to enforce the correct implementation of these procedures. The nurse can be a CNM's greatest ally or can be her most significant foe. The nurse can present her support or challenges both openly and subversively. This subversion can be exhibited by wasting another person's time, money, energy, or ingenuity, thus effectively changing a positive relationship into a disinterested, gratuitous relationship (Bourdieu, 192). These behaviors could create both positive and negative effects on a nurse-midwife's management of birth. Nurses can use various practices that control the environment of birth, controlling how the patient is traveling through the hospital system and delaying the notification of providers about changes in patient's conditions. Nurse-midwives are aware of many of these "hidden subversions" as they may often find themselves exploiting such practices.

> *The whole sugar and honey and flies thing, so I'm really nice to the nurses. I please and thank you and yes ma'am, beyond just general courtesy. Every time I go into a room and I come out, I find the nurse and say I checked her, her cervix was this, I've already put her on a strip, I just want to keep you abreast. And I think in return, most often, the nurses will call and let me know if something happens, she's ruptured or she's*

> *feeling pressure or whatever is going on. I think I've seen firsthand when you see some of the interns come in and they have a chip on their shoulder, the nurses can make your life hell and they won't tell them anything and they won't call them. And on the flip side, the interns don't say what they're doing and don't put on the strip and then, I mean, it's definitely like mutual disdain that can happen. But I try to always let the nurse know if I'm going to go in the room and I'm going to do something. Even if I don't need them present, just so they know that, hey, I'm going to go in and rupture her now. I'll let you know when I put her on the strips, that kind of thing. Kind of like when I put an order in the computer, I always let the nurse know I put an order in the computer so that she can look at it and do what needs to be done. If you don't, then there's like a bing or something that comes up on their screen so they know. So they have no idea. And when you've got multiple patients, it's hard to keep up with looking at every patient every couple of minutes to make sure – in addition to going in the room and just providing physical care with what's going on between the patient and the physician and everything else.* (Kim, Section 55)

Nursing staff is also dealing with their responsibility to be the primary individual responsible for knowing and understanding how the patient's needs and care fits into the hospital environment. They are also contending with their own stereotypes. Nurses are the caring, protectors of patients in the hospital. They work to coordinate the often competing recommendations of the patient's different health care providers. Nursing

staff is the front line workforce, key actors who can influence patient care. Nurses are there to meet the patient upon arrival at labor and delivery. Nurses can create the atmosphere which influences the patient's entire labor experience. Nurses are embedded in the discourses that have surrounded nursing through time and the stereotypes that have been associated with females, as nursing continues to be an occupation that consists of primarily women (91% of nurses are female (Landivar, 2013)). The nurse can use their capital to take advantage of their power and authority to support the decisions nurse-midwives make or they can undermine it. Nurse-midwives recognize this and work to build their support.

> *I would ask them "How do you think we should take care of this lady today? What are your thoughts?" That was so foreign to them. If she's doing great on eight of pit and she's making good progress, let's just leave it there. If you think she needs to go up… we'll do that, otherwise, let's just leave her alone… It was a good old boys club, and the nurses were underlings and they were so overworked and they appreciated me. They appreciated somebody who (will help out), I'll go in, I'll flip her…I'll chart my own stuff and I'd help (my patients) up to the bathroom and put them back on and get them back on the monitor and roll them, I'll always put the Foley in myself and clean up after myself and I'm not real mean to the patients… So just over time, they began to realize, wow, this isn't so bad.* (Nancy, section 42)

In general, the nurses are, we're a team, so they help facilitate all this. They have opinions about what would be helpful or not helpful for a particular patient, and I listen to that. (Olivia, section 88)

The nurses are the health care providers with whom the nurse-midwife works most closely, as they work side by side with nurse-midwives at the bedside. With this proximity, nurses have the ability to directly influence patient care on a moment to moment basis. This close association results in a significant influence on management and the implementation of the nurse-midwifery process of care.

(The nurses) have a huge influence on what happens in the labor room. I mean, they're the 24/7 provider. They're always there, thankfully. It could be very positive, but it could also – they try to influence your decisions. It happens every day you're on call where you'll have a patient and the nurse will say this patient's never going to make it or I'm no liking this strip… this is their patient, too. They need to give you their opinions and things. But... how do you not let someone have some impact or influence on you (while) someone stating something that they're not comfortable with. Of course you're going to take that into consideration. Of course that's going to have some influence probably over a final decision on something. I don't see how it couldn't. (Lisa, section 104)

The nurses that the CNM works with are not only those from labor and delivery, but also nurses from other patient units, including postpartum, newborn nursery, high risk nursery. The CNM must anticipate the needs of these nurses and work to meet their expectations in a way that will allow her patient to receive the care she wants her to have

in these areas as well. She forms relationships with these nurses, so that they are more comfortable reaching out to her with information and questions, so that she is able to shape the patient's care to align with the patient's expectations or work toward shaping the patient's expectations to align with the care, if a care plan is anticipated based upon hospital protocol that will not allow deviations. Through these relationships, the CNM gains the insight to be able to anticipate care in a variety of situations, thus being able to shape the expectations of those around her in a proactive manner.

Interactions with individuals who influence the management of birth.

In addition to nurses and physicians, nurse-midwives must also interact with and form relationships with many other individuals within the hospital arena. These include unit secretaries, cleaning staff, respiratory therapists, anesthesiology, laboratory and all the individuals who form the patient's support group, including family members, friends, spouses, and doulas. These individuals must all have their expectations evaluated and shaped by the nurse-midwife, as these people all have subtle and not so subtle direct effects on the patient both during and after her birth. The nurse-midwife is working to create an environment that supports the wishes of her specific patient. These wishes may vary from patient to patient and the feedback that the patient receives during her admission to the hospital and early interactions with staff impacts her experience. As hospitals have become more cognizant that patients are consumers, there is an increasing awareness that first impressions count in patient satisfaction (Nicoloff, 2012). Thus when a woman is admitted to the hospital this first impression can make a difference in the experience of birth.

In the background of all of these interactions is the hospital administration. The priorities of these individuals have a significant and concrete influence on nurse-midwifery care. They create the professional climate and the atmosphere that allows the nurse-midwife to interact outside of the expected plan of care to create the laboring experience desired by her patients.

> *The administrators in the hospital are very influential on the culture of care and on how care is delivered and how care is offered. For instance, if you work in a hospital that is very concerned about turnover in their rooms for a profit standpoint or from a staffing standpoint, and they want everyone to stay on the Friedman's curve because they want that labor room vacated within ten hours, then that's going to affect the way that I deliver care. So I think yes, definitely, from the ground up or from the top down, administration really impacts the way that we deliver care.* (Tammy, 76)

The administration of the hospital also possesses decision making authority to order or have specific equipment available in the labor and delivery unit. These individuals made the choices that informed the architects who created the initial unit design. They also influenced the selection and use of the various fetal monitoring equipment, centralized monitoring, electronic charting, availability of alternative pain options- including baths, showers, birthing balls, birthing stools, and access to new or alternative labor treatments.

Administrators must focus on maintaining financial balance, and navigating the activities of staff for this institutional purpose. Financial choices are often made by

administrative individuals within the hospital system with input from the various medical committees. However, often these medical committees do not have allied health professional representation or only have limited allied health professional representation. (Nurse-Midwives are considered allied health professionals within the hospital system.)

> *The negative factor… it's thrown in your face when you request for different things to help you work smoother, you're seen as a nonprofit generating… that might delay you getting something as opposed to the surgical unit, which is seen as revenue generating, so they get everything they want and you feel like the stepchild. You have to wait.* (Sue, 32)

Other social actors from outside the immediate hospital environment who are welcomed into the birthing space also have an impact. These actors include doulas, labor support individuals, students in various health care professions, and the patient's family and friends. These individuals bring with them many discursive attitudes and information. The nurse-midwife must be able to analyze the relationship between the laboring woman and these individuals, assessing for positive and negative influences and intervening when necessary in order to support the woman's specific wants and needs. The CNM must often be a master negotiator in order to work towards getting her patients needs met without ostracizing individuals who are a significant part of her patient's life.

> *This woman… was starting to push with an epidural and the head was really low and the family had the TV on, and they're watching the TV, they're not giving her any attention. And there was a part of me that was like this isn't working, this doesn't work. And so I actually turned the TV off and I said to them, you need to participate in helping her, we need your*

help here. We need your prayers; we need what you can give. And in fact, it was interesting because someone was sitting behind the curtain and… at one point I said you know what, I think you really need to leave because I was like, look, people need to contribute to what's going on here. And the whole picture of her pushing changed as soon as the family got involved. And it was really obvious, obvious to the point where I… (to the other staff) said what happened? What switched things in this room? And she said when you go the family involved, when you made them turn off the TV, they got involved and they pushed their attention toward her. (Gale, Section 64)

Interactions with clients/patients.

Patients are an integral component of this environment and can become stereotyped as well. They can be viewed as needy, demanding, often unintelligent and sometimes passive. They can be seen as a collective whole. Sometimes they are seen as an individual with unique requests that may often be hard to accomplish. The patients of nurse-midwives are also women. As women, they are also labeled by the persona of women in our society. Women can be viewed as impressionable, fickle, moody, overbearing, compassionate, strong and/or benevolent. These impressions reflect on how their relationships affect their interactions with their providers. Patients were the focus of all the actions of nurse-midwifery care. The nurse-midwife sought to learn what each patient wanted and desired from their birth experience. The nurse-midwife then integrated these specifics into their management of that woman's labor. As the one individual that the nurse-midwife sought to serve, the patient has significant potential

control over the nurse-midwife's actions. The nurse-midwife would shape her plan of care to fulfill the goals of the patient.

The Field of Nurse-Midwifery Care

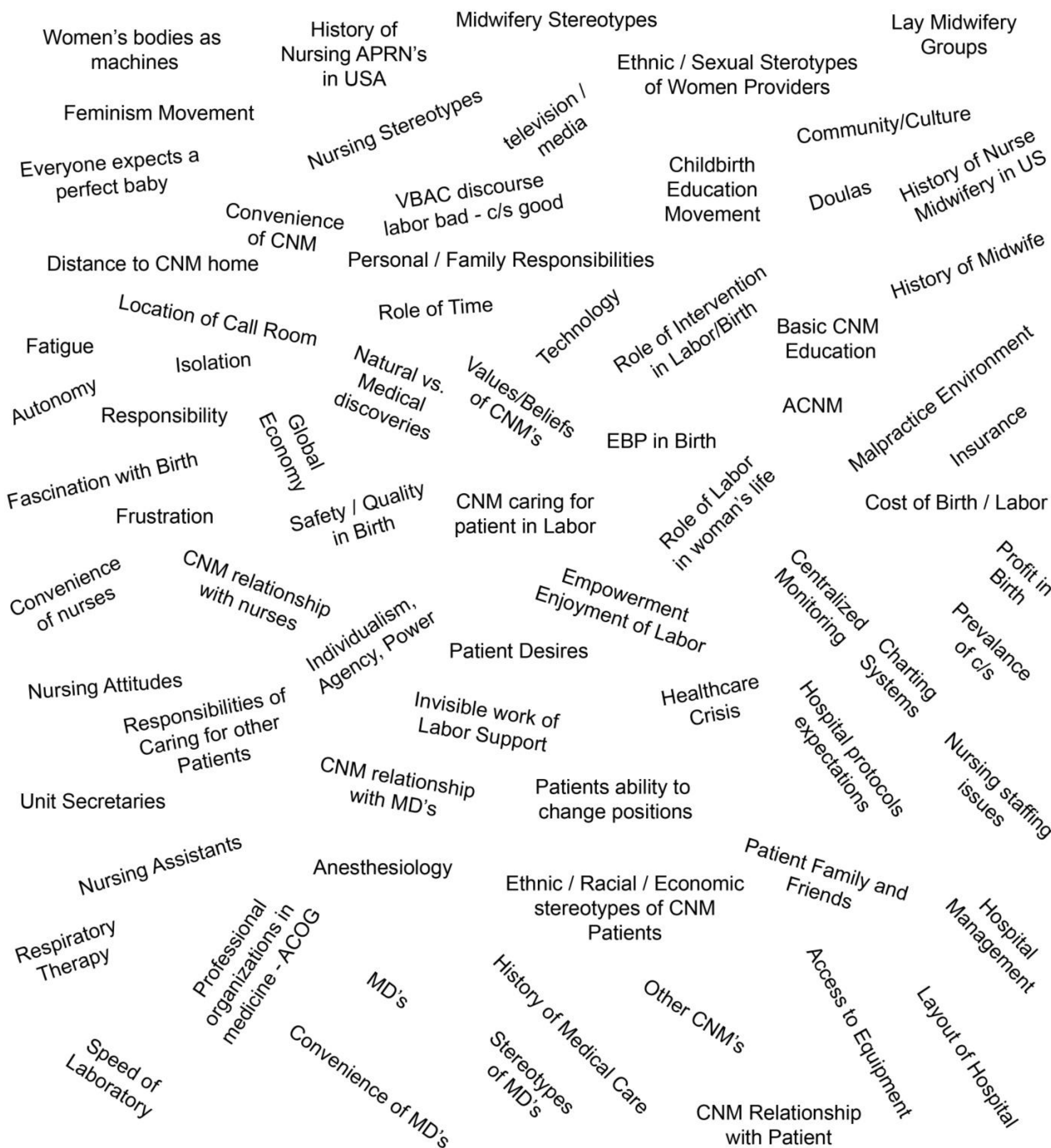
"Discourses are distinguished both by their ways of representing, and by their relationship to other social elements"(Fairclough, 2003, p. 129). These discourses become evident when we look deeper into the environment in which action takes place. Within the hospital environment, the nurse-midwife is directly influenced by her immediate surroundings and those within those surroundings. However, the lines of influence do not end there and extend significantly outward. From the immediate physical environment to the role of litigation in our society, nurse-midwives must internalize and deal with these influences as they provide care to their patients. These factors are embedded in the nurse-midwives field and as such influence her provision of care. These influences need to be understood so that a foundation for how the nurse-midwife provides care can be contextualized.

Exposing the field via situational analysis.

Analysis of the field of nurse-midwifery care began with analyzing and coding the transcripts for people, things, ideas, or other factors that influence the care that they provide. This conglomeration of entities were brought together in a messy working map (Figure 3, 9), designed to function as a basic map of influencing factors. This list was expanded based upon insights obtained through literature review, internet searches, additional interviews, discussions with committee members and personal experience. The messy working map (Figure 9) was created early in the analysis process to represent

the numerous factors that affect the central component, which is the CNM caring for a patient in labor.

Figure 9: Messy Working Map of CNM Caring for Patient in Labor



The next stage in the analysis process consisted of creating multiple memos about the relationships between the different components and the core idea. These memos set the stage for organizing the environmental factors into an organized situational map, leading to figure 10. The ordered map allowed for bringing associations together, so that an understanding of their influence can be appreciated.

Figure 10: Ordered Situational Map of CNM Caring for Patient in Labor

Individual human elements/actors
CNMs
Patients
Nurses
Physicians
Nursing administration
Doulas
Anesthesia
Newborn nurses/Respiratory Therapy
Patient's Family and Friends

Collective Human elements/Actors
ACNM
Other professional organizations (i.e. ACOG, MANA, ANA, etc.)
Hospitals, hospital chains, hospital organizations- AHA
Insurance companies (HMOs, state and private insurers)
Childbirth organizations
Lay Midwifery organizations
World Health Organization

Discursive constructions of individual and/or collective human actors
CNMs as barefoot, dirty, uneducated purveyors of birth
CNMs as helping women only without pain medication or technology
CNMs as delivering patients only at home
CNMs as advanced practice registered nurses
Sex/gender stereotypes of CNMs versus MDs
Nurses as caring, good mothers, protectors
Nurses as submissive to decisions of MD
Patients as needy, demanding and/or unintelligent, passive
Everybody is different- every person is unique
Physicians as controlling, interventive, focused on tight time-line for labor
Administrators as caring more about finances than patient care
Anesthesiology wanting every patient to have epidural

Nonhuman elements/actants
Information technologies
External fetal monitoring equipment
Electronic charting
Centralized monitoring
Limited supply of operating rooms
Limited supply of L&D rooms
Limited supply of postpartum rooms
Presence or absence of labor support equipment (i.e. balls, tubs, towels, linen)
Cost containment goals
Patient Satisfaction goals
Old, current, new medical technologies, medications, interventions in labor, birth
Profitability of labor/birth
OB profits keeping hospitals afloat that would otherwise close

Implicated/Silent Actors/Actants
Patients
Patients' family and friends
Unit Secretaries
Nursing Assistants
Laboratory Staff
Other midwives
Doulas
Other MDs with privileges at same hospital as CNM
Nursing administration

Discursive Constructions of Non-human actants
Technology as life-saving
Technological care as being best care
Intervention as always positive
Intervention as "bad"
Public relations of hospital/ hospital advertisements of L&D
Hospital as locus of complications (iatrogenicity)

Political/Economic Elements

Global economic situation
US and State fiscal deficits
Politic of high cost of health care and health care reform
Quality and Safety in birth
Rising costs of childbirth
Use of EBP in labor/birth
Increased profits for hospital and MD if patient delivers via cesarean
Randomness of labor resulting in inability to control length of birth process resulting in increases in staffing needs/costs
VBAC discourse: Labor is bad -> cesareans good
Consumer activism and reproductive rights

Sociocultural/symbolic elements

Empowerment as important process of motherhood
Caring as important, skilled, professional work
Variations between expectations and needs of caregivers and patients
Labor as painful, non-purposeful, and optional process
CNMs as providing continuous bedside labor support
SES/ ethnic/ racial stereotypes of CNM patients
Autonomy/ responsibility are important in CNM role

Temporal elements

Caring/relationship building as invisible work that takes time
Invisible work of labor support
Time requirements of labor support
Spontaneous labor often at night, making labor support invisible to MDs, nursing administration
Overtime issues
Invisible work of developing trust with nurses/MDs to improve labor management of patients
On-going negotiations for use of individualized labor management techniques

Spatial elements

Distribution of patients in L&D
Location of patients that CNM is also responsible for (i.e. postpartum patients, patients in office)
Layout of hospital
Location of operating rooms from labor suites
Distance between location of backup physician and L&D
Location of centralized monitoring equipment
Location of labor support equipment
Size of labor rooms
Size of labor bathrooms
Location of call rooms
Distance to CNM home

Related Discourses (Historical, narrative, visual)

Role/purpose of labor in a woman's life
History of midwifery in the United States
History of nursing
Nursing stereotypes
Stereotypes of the female gender over time
Role of APRNs in health care
Role of MDs
Role of nurses
Childbirth movement
Feminist movement- women's rights to self-determination
Health care crisis in United States
Media Coverage of birth (baby channel, labor as 30 minute television show)
Celebrity endorsement of cesarean birth (celebrities choosing primary cesarean)
Lay midwifery movement
Recent publications around birth: e.g."Birth", "Pushed", "American Way of Birth", "Born in USA", "Business of Being Born"
Women's bodies as machines
Discourses about agency, individualism, power
Successes of modern medicine: Everyone expects a perfect baby
Universality of technology as positive

Major issues/debates (usually contested)

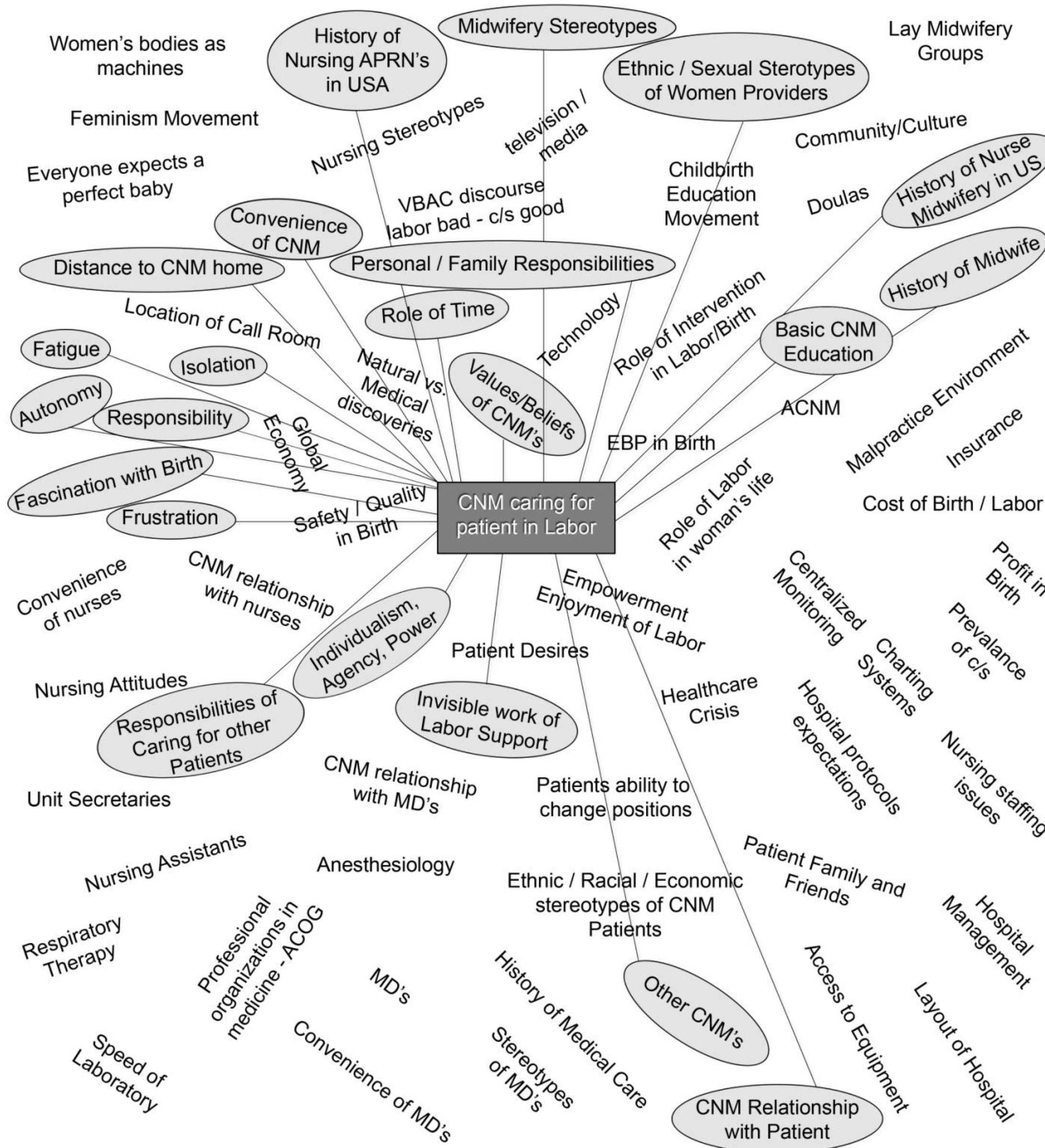
Future role of CNMs in birth
Ultimate control of birth by MDs
Consequences of separating patient from or eliminating labor (including: emotional, hormonal, role transitions)
Billing for invisible work
Value of invisible work of labor management/support by CNM
Role/Purpose of labor in a woman's life
Value of woman having positive experience of labor and birth

Emotional/Mental Elements

Fatigue
Isolation
Frustration
Fascination with birth
Weight of personal/ family responsibilities
Support of physician back-up
Support of hospital administration
Satisfaction with salary/payment for services/ benefit
Emotional satisfaction (or lack of) with role
Emotional connection with patients

After organizing these environmental factors, I then moved into looking at relational connections. The relational connections are the associations between factors that have the most influence on nurse-midwifery management and allow for greater depth and analysis of these components (Clarke, 2005). This map highlights the complexity in the field of nurse-midwifery management of birth. Each of these factors is related to the moment to moment care that the nurse-midwife provides. These items could be compared to the balls that a nurse-midwife has tossed over her head at any given moment. The CNM must deal with all of these factors as she provides care. These highlighted factors are not necessarily directly related to care management, but rather are related to how well the nurse-midwife is able to integrate the responsibilities of her personal and professional life. These are typically factors that are not visible to patients and the nurse-midwife may often be unaware that she is dealing with these. Fatigue, isolation, frustration, family responsibilities and knowing she may have a long drive home after call may all decrease the nurse-midwife's motivation to fulfill the varied needs of her patients. At the same time, her fascination with birth, support from other CNMs, and an expectation that because she is a woman, she also provides mothering compassion, may all lead toward increasing her motivation to go the extra step to support her patients. In the next section, I will discuss these associations in greater detail.

Figure 11: Relational Connections around Personal Factors affecting CNM Care



With regards to figure 11, as I analyzed the actors and connections, the field of nurse-midwifery care expanded significantly outward from the birthing room in the hospital, to a more global economic context. It also encompasses the history of women and childbirth across time and space. I will now go into further detail about the relationships of some of these collective actors and connections that affect nurse-midwifery care.

Collective actors and connections affecting nurse-midwifery care.

Looking deeper into the connections between the actors on the ordered situational map, it becomes clear that there are several groups of collective actors whose discourses affect the relationship between the nurse-midwife and her patient. Examples of these groups include the professional organizations of the key social actors in the immediate nurse-midwives field: the American College of Nurse-Midwives, the American College of Obstetrics and Gynecology, the Midwives Alliance of North America, the Association of Women's Health and Neonatal Nurses, and the American Nurses Association. Each of these organizations make statements which influence the attitudes and beliefs of the public, filtering into the professional relationship. Other organizations from childbirth associations, doula associations, hospital associations, and insurance companies also impact the care provided by nurse-midwives. These organizations present varied and discursive constructions of the reality of health care in the United States.

Expanding from this immediate environment, one can begin to see that the impact of the current political economy influences the birth process. Currently, we exist in the midst of a major health care crisis and contested arguments abound as to whether the provision of health care and coverage for hospital care is a right for all or a privilege for those who earn enough to pay for insurance. Our states, our regions, our country and our world are in the midst of major economic fluctuations and health care costs in the United States constitute a substantial part of the US budget. The United States spends almost $7000 per capita on health expenditures, nearly twice the global average (Organization for Economic Co-operation and Development & Institute for Research and Information in Health Economics, 2008).

As intervention in birth increases, the cost of birth also increases. When unemployment increases, there are less insured patients. With more people uninsured, the expenses of Medicaid covered births increase. Over the past 15 years, reimbursement to providers and hospitals for Medicaid deliveries have increased and in some states can approximate the reimbursement amounts for private insurances. When this occurred, many private OB/GYN practitioners who had previously only accepted private insurance started accepting Medicaid. This Medicaid population moved away from locations with many supportive services, including the Women's Infant Care Program (WIC), social services, pharmacies, and transportation access. Many of the new practices serving the Medicaid population had no knowledge of, or access to, these supportive services.

The field of nurse-midwifery is also influenced by the national discourse about vaginal birth after cesarean (VBAC). Many popular and professional groups, organizations and individuals have opinions on this topic. For example, the media shows very positive images of cesarean birth, with stars such as Brittany Spears and Posh Spice choosing elective cesareans as a way to protect the integrity of their vaginas. Many books in the lay media also present positive images of cesarean birth, such as *Fifty Shades Freed* (James, 2011), which presents cesarean as the idealized type of delivery that is safest for both mother and child. Many consumer groups have formed in resistance to the critique of these procedures, and much lay literature now exists with a more critical view of elective cesarean (Block, 2007; Cassidy, 2006; Jacobs, 1993; Mitford, 1992; Simonds, Rothman, & Norman, 2007; Taylor, 2002; Wagner, 1994). This discourse extends into the medical management of VBAC as well, with the National Institutes of Health (NIH) sponsoring a consensus development conference on March 8-

10, 2010 to look at VBAC in more detail in the United States (F. Cunningham et al., 2010). Trends, benefits, harms, and factors influencing trials of labor after cesareans were evaluated in detail. The fact that this consensus development conference even took place at the national level highlights the significant change in obstetrical management that has led to the current one in three cesarean rate in the U.S. The complexity of the issues addressed, while discussed by this national committee of experts, must be dealt with every day by each and every provider of obstetric services in the U.S. The current discourse on VBAC, therefore, is a central component of the field.

In labor and delivery units across the United States, sophisticated technology has become part of the field, often introduced without clear evidence of its benefit (Wagner, 2000). Since there exists a choice to use the various elements of technology for the monitoring and surveillance of labor, or for the comfort of laboring women, nurse-midwives must be conversant about their benefits and potential risks to the patient during her labor. Both the content and the relative emphasis of the value of these technologies in nurse-midwives' statements encourage or discourage their use. Nevertheless, their existence requires all involved actors to address. These technologies may include information technologies such as fetal monitoring equipment, centralized fetal monitoring, electronic charting, and labor support equipment, to wit, birthing balls, stools, tubs, towels. Through the use of these technologies in birth, managers of the process make a statement about the role of people and objects in the birth process. They have to decide whether the typical patient is healthy, without the need of outside support or at risk for complications needing technological support. The architecture of the space also plays a part in these decisions. The numbers and layout of the birthing rooms, the

availability and access to operating rooms, and the available supply of postpartum rooms all impact upon decision making, both directly and indirectly.

The use or non-use of technology within the birthing process can place the nurse-midwife in the midst of a discursive war, where her language describing the intervention aligns her with either the medical model of obstetrics (which is prevalent in the hospital system) or the holistic birth model (which is prevalent in the alternative birth movement). This dichotomy must be reconciled by every nurse-midwife, as her value and belief system places her at the middle of this argument. She believes in allowing labor to proceed normally, i.e. without intervention, at its own pace as long as progress continues. Concurrently, she values medical management, which may include intervention without physical indications. Both of these values must be confronted during every patient's labor process. A detailed description of how the nurse-midwife deals with the confrontation of these values evolved from the textual data collected from the interviews in this study.

Nurse-midwives are also dealing with discourses that are often invisible to the public. Nurse-midwives value caring and empowerment as important components of skilled, professional birth support. The expression of the values of caring and empowerment are very hard to quantify during labor. The benefit of nurse-midwives providing continuous bedside labor support has not been linked to a billable code. Nurse-midwives also view autonomy and responsibility as integral to their management. This can be contested by the various providers in the field.

There exists a major contested political discourse about who has the ultimate control of birth. Labor is often understood to be a painful, without purpose, and thus, an

optional process within our health care system. Medicine has the ability to erase the pain and the actual process itself. Medicine is also situated within a health care that must serve the needs of the patients, the needs of the providers, and the needs of the system. Research is still evolving on the role of labor and birth on the emotional, hormonal, mental and physical transitions to motherhood. Currently in the United States, the popular expectation for a perfect baby is reinforced by lay media, literature, hospital systems, our court system and our health care providers.

Physicians, nurse-midwives and nurses who attend birth often find themselves working at night. This reality is often invisible to the people involved in the management of the birth environment and those who establish work requirements. As such, nurse-midwives often are tired, work in isolation and deal with frustration towards the system.

> *I feel like I spend a lot of energy just trying to survive, and I feel like I don't get to touch the people the way I want, and I feel like sometimes I'm getting lazy because I know it's going to be a battle and I might not get it done for them… and sometimes it hurts when you try and you can't get what they wanted. When that mom looks at you and tells you she had a really bad experience, she couldn't hold the baby last time, and that's all she wants, and then that's all everybody's against, it's torture. Oh, it's just so maddening... I want to be a bad ass. I want to say, oh yeah, you don't want me to put her in the tub, well, I'm sorry go find another room then to work in and get another nurse because we're putting her in the tub.* (Frances, section 68)

As a profession of mostly women, CNMs must also deal with family obligations and responsibilities and the emotional stress over their roles or lack of roles in a fulfilling family life. Often in current society, women are expected to maintain the roles of managing the household and parenting simultaneously with full time employment. The stress of these concurrent demanding responsibilities affects every aspect of the nurse-midwife's life.

> *A lot of time I would be on 24 hour call and you would just stay at the hospital because you would do six, eight deliveries in a 24 hour period...And then I tried to ask for some flexibility because I was actually still breastfeeding him, my youngest, and I said is there any way I could come in early one day and leave early one day, because I was dropping the kids off at 8:00 and then (would be) one of the last people to come and pick them up, and they were like, no.* (Irene, section 18)

Over time, it becomes harder to compartmentalize these roles. Many nurse-midwives will delay entering the profession until after they have raised their families. This has lead to the aging of the profession with mean age of the nurse-midwife at 47 years (American College of Nurse-Midwives, 2012).

Many, nurse-midwives, however, do achieve the support of their physicians, hospital administration and satisfaction with their salaries, which allows them to sustain their day to day existence. However, it is the fascination with birth and the emotional connection they achieve with their patients that provides the drive to continue their work. This emotional connection to others is what feeds into and energizes the process of nurse-midwifery care. Nancy said this:

I think birth is awesome, I'm like look, look, look, open your eyes, look at what you did... And people come back and they're like, oh, thank you, you were so great. And I keep saying you did all the work… I just sat at the end of the bed. You're the one who did that, that was your accomplishment, not mine. I didn't deliver the baby, you did. And so my biggest thing is for them to leave feeling that that's something they accomplished, that is their baby, they earned it, they deserve (it), they're the mother, that's their baby because they accomplished this huge thing. I think that (birth is) a huge thing in women's lives. And it's one of the seminal events of an adult woman is to give birth. And you can't do that for everybody. For some people, it's always going to be something they survived. It's some heinous thing that was done to them. And I try really hard to make that be a really powerful thing, a powerful accomplishment. I know it was for me. I want everyone to feel the way I felt. I was hurting and I never wanted to do it again after the first time, which I did, I have two kids. But I knew that that was my baby…because I had killed myself to get him here. And I knew that I was fit and deserved to be his mother, because if you would do that for your baby, if you have a safe delivery and you push through the pain and get your baby safely here, I just think that it just changes your reality. Plus all of the endorphins and I just think it's a really awesome thing. (Nancy, section 110)

Shaping Birth by Connecting, Protecting, Intervening

Shaping Birth is the theory of nurse-midwifery practice that emerged from the data in my research. It is a process that begins with connection, and then moves into protecting and intervening. In the following sections, I will explain the main theory and then provide greater explanatory depth to the steps in the process. The 'nurse-midwife' (CNM) referred to in the following exposition of this theory, is a composite nurse-midwife that evolved from the analysis of the interviews with the research participants. This nurse-midwife is reflective only of the nurse-midwives that were interviewed during the context of this research makes no claim to be reflective of all nurse-midwives. Nurse-midwives, like everyone else, are varied in their behaviors and beliefs. This theory is representative of the constructed reality of the nurse-midwives who participated in this research.

Emergence and evolution of the Theory of *Shaping Birth*.

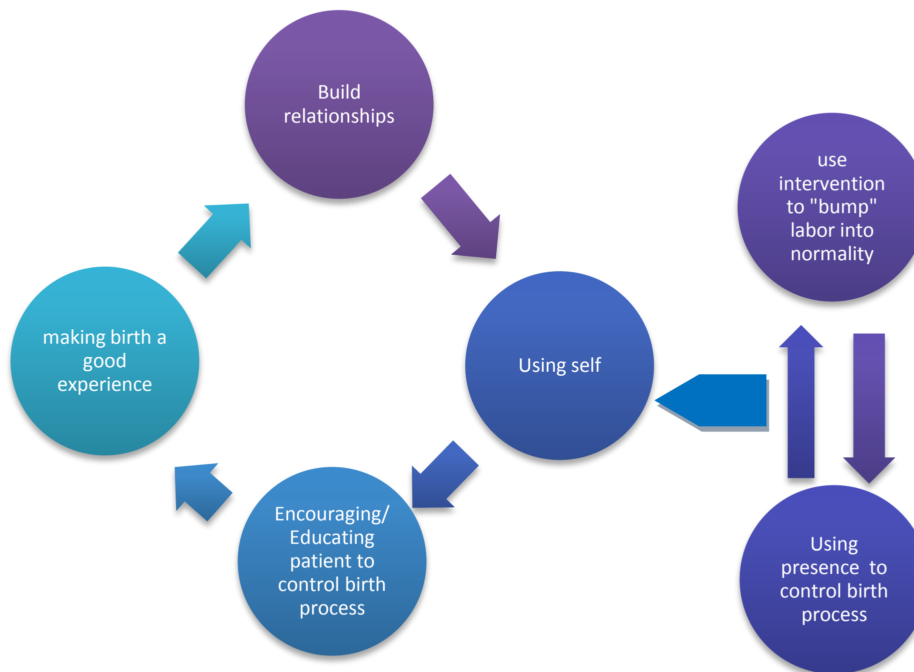


Figure 12: Initial model of Nurse-Midwifery Process

The initial draft of the model of shaping birth was visually a radial process (figure 9). As this research process advanced, several ideas came to light about nurse-midwifery care. The nurse-midwife built relationships with patients, physicians, nurses, families, communities and hospital administration. After the creation of these relationships, she would move back and forth between two tasks- 1) using medical or non-medical intervention to "bump" labor towards the midstream of normal/healthy birth (using personalized and individualized interventions) and 2) using her time, presence or absence of herself at the patient's bedside, and through educating the patient to control the care given and thus control the process of birth. The goal of both tasks was to promote vaginal delivery. Early in the analysis, it became clear that the CNM's desired outcome was a vaginal delivery. This was an interesting finding, as non-intervention was not the

primary goal. Previous theories of nurse-midwifery have focused that non-intervention is a goal of care (Kennedy, 1999; Lehrman, 1981, 1988; Thompson, 1989) and thus this unexpected finding revealed a new insight into contemporary nurse-midwifery. Non-intervention or supporting physiological processes in labor were appreciated as an ideal or a desirable experience, but this was not the goal for all labors. Instead the nurse-midwives were focusing on the goal of achieving the vaginal birth. This focus may be currently influenced by the recent NIH statements on VBAC and the multitude of publications that are currently available in mainstream media supporting vaginal delivery over cesarean birth. These influencing factors were discussed in the previous section. The nurse-midwives also spoke about wanting their patients to have a good experience. I created several memos where I struggled determining the aim of the nurse-midwifery process.

> *What is the ultimate goal in management? What is it that nurse-midwives are working toward? Is it the process or the outcome? They use these techniques over and over, focusing on treating each patient individually, but they still carry a huge burden when care moves away from a vaginal outcome, even if the patient specifically does not have an opinion about her route of birth. Is it the experience of birth or the outcome- vaginal delivery versus cesarean? If the relationship is important, how does this affect the goal of experience versus outcome? (MaryJane Lewitt, memo dated 8.20.11)*

These questions guided my subsequent interviews and analysis. As the analysis evolved, the concept of spending time with patients merged into the first phase of

relationship building. This addition was made, because the essence of relationship building was spending time with the patient to know her better.

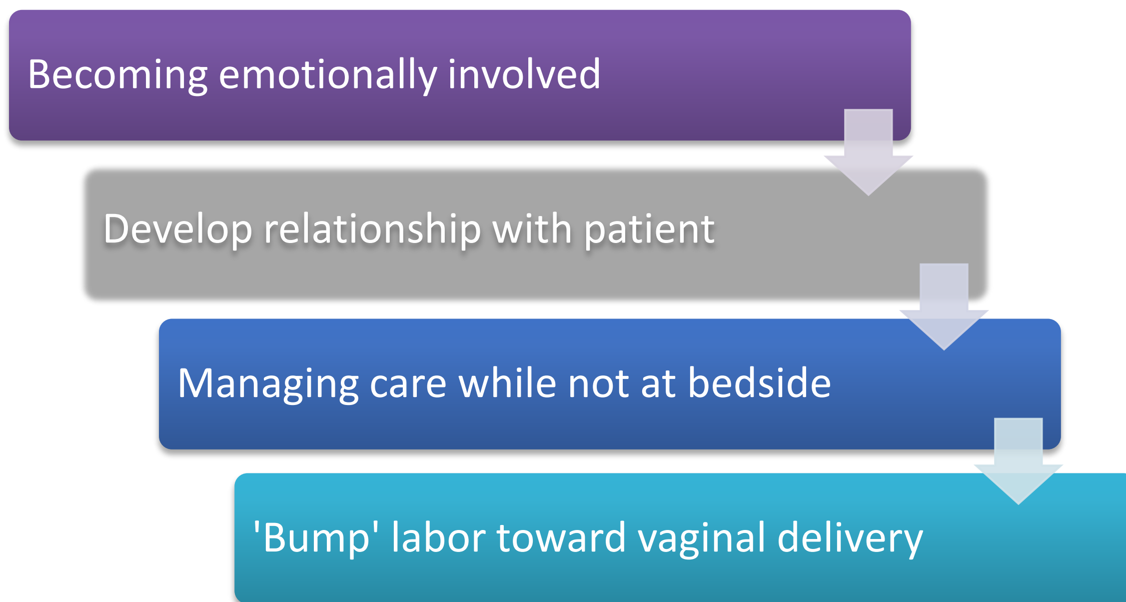


Figure 13: Intermediate Model of Nurse-Midwifery Process

The next version of the model had four steps (figure 13). It started with the nurse-midwife first becoming emotionally involved with the patient, and then secondly, the CNM would develop a relationship with the patient by spending time and encouraging the patient to make management decisions using personal encouragement and education. The third step involved managing care while not at bedside by developing trust with the physician and the nurse and thereby *protecting the patient from being "railroaded."* However, this step happened fluidly at all stages. The processes of developing trust with the nurses and physicians often happened outside of the patient's room. This step involved situations where the nurse-midwife did not pass complete information or avoided communication with physicians or nurses in order to prevent their patients from being treated via routine protocols or altering the management in a manner that may increase the patient's risk of getting a cesarean.

I would be monitoring a patient, watching them, and they (the physicians) would look at a strip from the office and call a C-section and not even tell me. (The physician said) "Well, she had one late." (The CNM said) "well, she just got her epidural and went and laid down, I haven't had a chance to fix her" and they (the physicians) come rushing in there and C-section them right out from under me. And that makes me a failure, it makes me – I had no control, and I knew that was just a travesty and the same thing with progression of labor with them. It's like "well, when was she last checked? She'd better do a centimeter an hour or we're cutting," there would be "no, well, let's see if we can fix it, give them an hour to rest, do something different," there would be no chance for me to intervene. They didn't trust me at all to fix anything and that was very unsatisfying because then you can't look at the patient in the eye and say this is what you need. And I believe it. I go, "Well, the doctor is on the phone and she feels like this is what you do." But you're still lying if you don't tell them the truth. I don't believe it, but he trumps me, she trumps me. And that's very – I hate to hear that people are railroaded, and they are being railroaded, every patient was induced by 39 weeks, they just told them, well, we'll induce you on your 39th week to the day, whether you're ripe or not, or whether your blood pressure is high today, go to the hospital. I don't care if you're 34 weeks. We'll induce you, then it won't work, then we'll section you. (Carol, Section 56)

The fourth step in the second iteration of the model involved using intervention to "bump" labor progress toward a vaginal delivery. The nurse-midwives described using intervention not because it was necessarily expected or protocol, but instead using selected interventions with the goal of achieving a vaginal birth. The nurse-midwives used a very broad definition of intervention, as they considered positioning, activity, and hydration right alongside with oxytocin, artificial rupture of membranes, and medical forms of pain relief.

> *(Healthy, normal labor) is a wider path… (Intervention is) sort of like a bumper on the side of the path and you are like bumping them back into the path to keep them moving forward. It's not like (the patients) are on a track necessarily, like… you are attached to one rail and you are moving along; it's like you are within (the wider path with bumpers on the side and you can vary within that path), so… normal (labor) can be kind of within the bumpers.* (Beth, Section 94)

> *(Intervention) is anything that we do to the patient, so it can be something as small as we get them out of bed or we encourage them to get into a different position or we massage or things like that, all the way to putting in internal monitors or doing a c-section or anything like that.* (Beth, Section 109).

The model evolved into its next iteration when *protecting the patient from being railroaded* became encompassed by the overall concept of *protecting*. The nurse-midwives created relationships with physicians and nurses, with the goal of protecting

their patients. They worked to create positive, supportive relationships with these providers, so that trust could be established. With the presence of trust, when the nurse-midwife desired to alter the plan of care from the routine, she could receive some latitude, based upon their experience with her and expectation that she would maintain a baseline of safe, quality care when working with her patients. It was with the emergence of the major theoretical construct of *protecting*, that I started to relook at the other stages of the process.

The third iteration saw the consolidation of the first step into a single concept of connecting followed by *protecting* and ending with a final stage of *progressing* or *midstreaming*. However, progressing and/or midstreaming did not adequately describe this stage in the process. The activity of this stage was doing things to the patient (which might involve medical and/or non-medical intervention) to encourage the patient's progress toward a vaginal delivery. This stage also includes making labor a good experience for the patient and making labor progress. The "doing" part of this stage involves the nurse-midwife *intervening*, which carries with it some historically negative connotations within the professional arena of midwifery. However, the definition of *intervening* in this context is not exclusively medically based. Intervening has a broad definition inclusive of all activity the nurse-midwife does with the goal of encouraging a change that is supportive of labor advancing to a vaginal birth and reflective of a good experience for the patient. This wide definition is supported by the nurse-midwives interviewed during the course of this research. So the third step in the model became *intervening* completing the final model of *Shaping Birth*. I continued collecting interviews after this model had emerged from the data, continuing to seek additional

information that may show any omissions or situations where the model would not fit. After the conclusion of the structured interview, I discussed the components of this model with the last five nurse-midwives that I interviewed. Overwhelmingly, they noted resonance with their practice of nurse-midwifery and did not offer any situations in which they foresaw incongruity with their provision of care.

Shaping Birth: The nurse-midwife process of care.

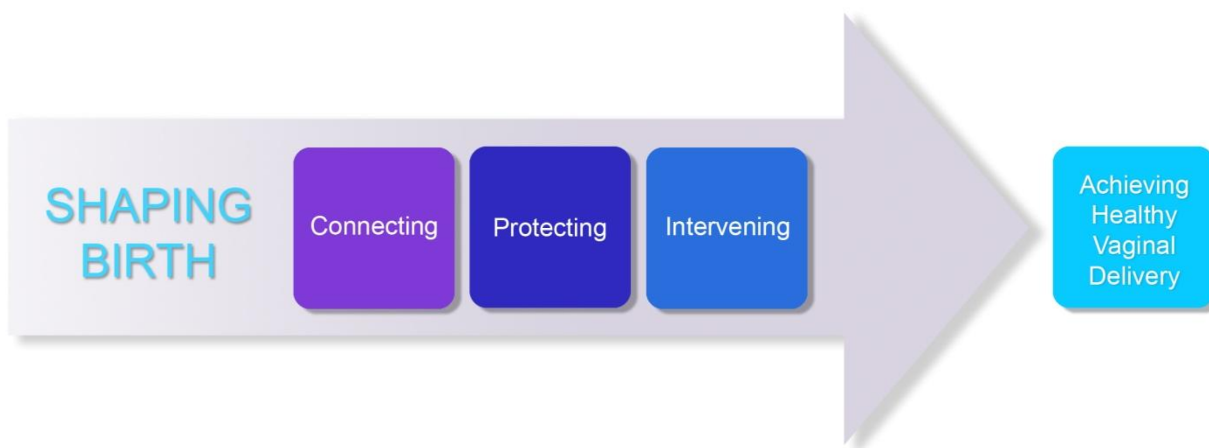


Figure 14: Shaping Birth: The Nurse-Midwifery Process of Care

The nurse-midwife is a modern shaper of birth. She creates a relationship with her patients in order to gain an understanding of the patient's unique needs and expectations. Taking these into account, the nurse-midwife then negotiates with the other members of the health care team with the goal of achieving and protecting the patient's needs and expectations of a good experience. Within a context of maintaining the quality and safety of the birth process, the nurse-midwife will intervene with her silence, her observation, and her support of physiological processes until alterations in the patient's status indicate that a shift is occurring away from labor advancement towards a healthy vaginal birth. When the CNM notes this shift, she will problem solve (involving her

patients and colleagues) and then implement interventions that are supported by evidence-based research, the desires of her patient and her clinical expertise. In this way, the nurse-midwife will connect, protect and intervene, thus *shaping the birth* of her patients.

The components of *shaping birth* emerge from the main steps in the process. I will now move into a discussion of each step in the process.

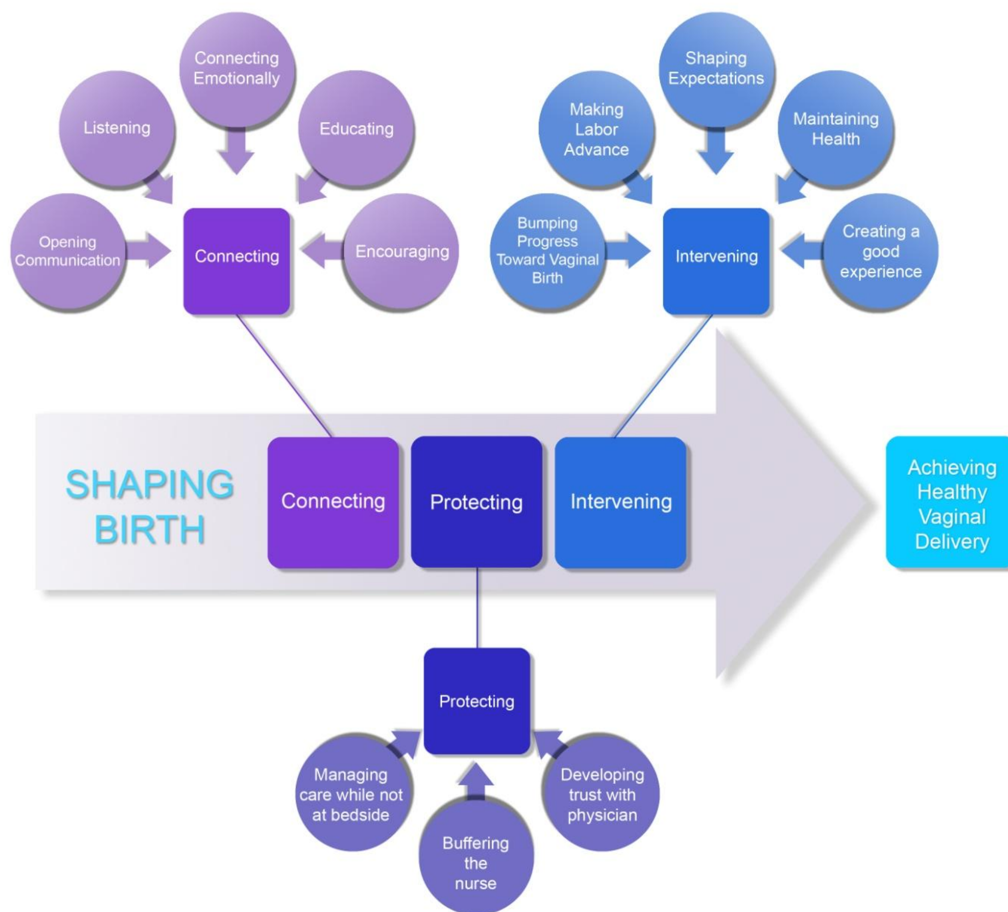


Figure 15: Expanded version of Shaping Birth

Connecting.

The first element of shaping birth is the establishment of a connection with the patient. Connecting involves talking with the patient in the office; asking that patient what she wants and desires when she arrives in labor and delivery and showing concern to her family by being present and available. The nurse-midwives spoke repeatedly about creating relationships with their patients and how they went about doing this. The creation of a connection with each patient was a significant focus of every nurse-midwife that I interviewed. Each one spoke at great length about how the connection with their patients was the foundation of everything else they did.

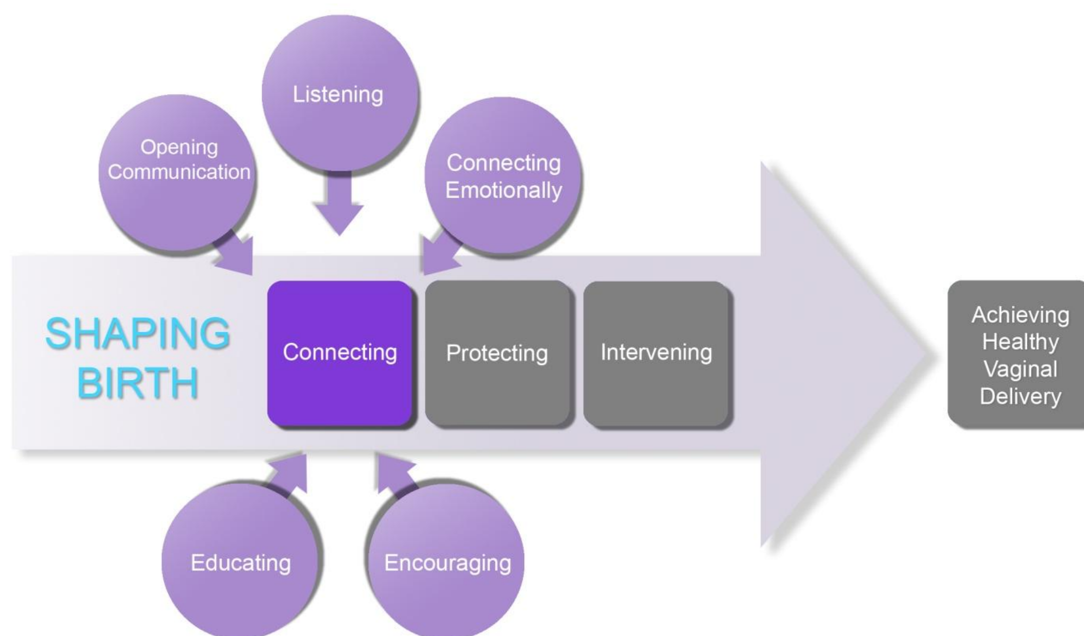


Figure 16: Connecting: The first step in Shaping Birth

The CNM will spend time with the patient specifically concentrating on communicating openly about her wants and desires during her labor and birth process. Through doing this she is forming and developing a relationship that will last throughout the laboring woman's birth experience. *"I would say is midwifery care is about building*

a relationship, you want to trust me, I want to trust you..." (Irene, section 74) This phase begins with opening communication with the patient, moves into listening to what the patient has to say, then the core of this process takes place- which is connecting emotionally, and finally the nurse-midwife focuses on educating and encouraging as mechanisms to continue to connect with her patients. *"I think we were meant to bond and be close and know the patient and be there for all of it*" (Carol, section 14). This process of talking to the patient takes time, as the CNM must get to know the patient and discover what her individual needs are. This involves individualizing care, getting to know what is needed by this person during her birth experience. *"I think most midwives, even if it hasn't been pre-established, we can establish a relationship with people pretty quickly by being present, addressing issues and concerns of women. But for me, it's having that relationship, building up that relationship, so that way, when it comes time to giving birth, being open and exposed and trusting, it's easier, so I think that helps facilitate the birth process."* (Irene, section 29) Nurse-midwives spoke over and over about the importance of their relationship with their patients.

> *I just really felt like I needed to go the extra mile with her and she really wanted to give up and give up her dream or idea of having natural birth. And I really worked with her and her husband in getting her sort of situated and getting her to stand and refocus and get her back into her mode and she was transitioning and was having a really hard time. And I got her in bed and she wanted a hands and knees birth, and she told me that from the beginning and so that's what we did. And she delivered, just a beautiful delivery, uncomplicated and it was really nice because later,*

she wrote me a note. And it's always – it's few and far between that you get a personal note from somebody, but it really makes you feel good because she's saying I really wanted to give up and you really encouraged me and my husband. So every time you came in the room, you made him more comfortable and made him feel at ease because he was very nervous and didn't know what was going on and was very scared and they felt reassured and she said it was just a beautiful experience. (Lisa, section 31)

I had never met this patient. I walked in, and she was great, very calm, but she didn't do her breathing and everything when she had her contractions, she would be very calm and with it totally conversational to me. So we kind of established this nice little rapport…she was really conversational in between contractions, so I was really enjoying being in there and getting to know them and we were building a really nice rapport with each other and it was fun. (Dorothy, section 79)

This step of spending time getting to know the patient, also serves a dual purpose. As the CNM learns what the patient needs or wants from her birth experience, the CNM is also connecting on an emotional level with the patient.

You click with some people, that's just human nature. You connect deeply with some people on some level, just, I don't know what it is. I think we're all like that, you're just attracted to certain people that, I don't know. And it goes across the socioeconomic, it's not necessarily like oh, we're in the same situation, we're both white, we're both middle class or whatever.

It's not like that. It's just some people you just feel drawn to. I don't know, I guess she just sparked something in me. (Lisa, section 36)

The nurse-midwife wants to connect with the woman emotionally. She needs to know what is important to her and by determining this, she is able to problem solve ways that she, as a provider, is able to assist her in the hospital environment.

I always, when I go in, try to discuss with the patients what their choices are, what their plans are, what I can do to help them and to honor what they want from their birth experience. I try to involve women's mom or sisters or friends or husband or boyfriend or whoever as much as I can. And mostly, I just try to honor whatever their wishes are. (Jill, section 58)

This emotional connection is often stronger with patients who need more help from the CNM, such as patients who prefer physiological birth. It may be weaker with patients who are choose epidural anesthesia. The nurse-midwife has an innate desire to help and be useful. This reflects back to her habitus which evolved from her motivation to enter the profession and contextualizes her values and beliefs. Those women who need more support will often find their nurse-midwife bonding with them more closely.

I mean, once they get the epidural, they're fairly comfortable, you're still in touch with them and talking to them and doing everything you do. But I don't know, I guess you don't feel like they need you as much, as far as labor support and whatnot. So maybe you hold back or you're maybe not as involved in those patients' labor. (Lisa, section 71)

As the CNM creates a relationship with her patients, she is also providing education and encouragement. She wants to help the patient be more involved in their

own care processes, by participating in decision making related to the management of labor.

> *So you go in, you meet your patient, you find out what her expectations are because that's what you have to say, so one of the first things I say, especially when they're like in an early labor and it's their first baby, is what is your plan for pain management? And quite often, they say, well, I don't really know. Before they've even gotten there I'm hoping somebody, if not myself, has said, you need to learn about everything because until you know how it's going to affect you, I don't want you being afraid of an epidural because you never learned about an epidural, therefore, when you're hurting and that's the last thing there, I don't want you to be afraid of it. So I want you to be educated…. When I walk in the door and you look at me and say, … I can't do this anymore, I can't take it, then you know what I have to offer….And then I assure her, just so you know, you are not going to get anything unless you ask for it…So we're going to try to make this, as long as you stay healthy and as long as your baby stays happy, we'll do whatever you want to do.* (Anne, section 26)

> *I do feel like a woman has a right to choose if she wants to refuse certain things. But I think education is the foundation of that. You can't just throw it out there and tell them you can deny this, but they need to know what it is.* (Carol, section 24)

> *I can help you just a little bit and have a really – I am not making the decision for her, I'm making it with her is the best thing I can do. It's a kind of informed consent, they need can either do it this way, and this is the risk and benefits… or we can do it this way and allowing her to choose which way to go and that's actually the best way to do it.* (Dorothy, section 122)

Connecting occurs with the nurse-midwife seeks and forms a relationship with her patients. This is the first task the nurse-midwife will undertake during her interactions with patients. She seeks information about the person her patient is and shares of herself. Through this exchange, the nurse-midwife is able to assess for knowledge, desires, and the patient's personal goals for her labor. While the depth of this connection may vary between patients, this connection remains the motivation for the nurse-midwife to continue to intercede throughout the other steps of this process.

Protecting.

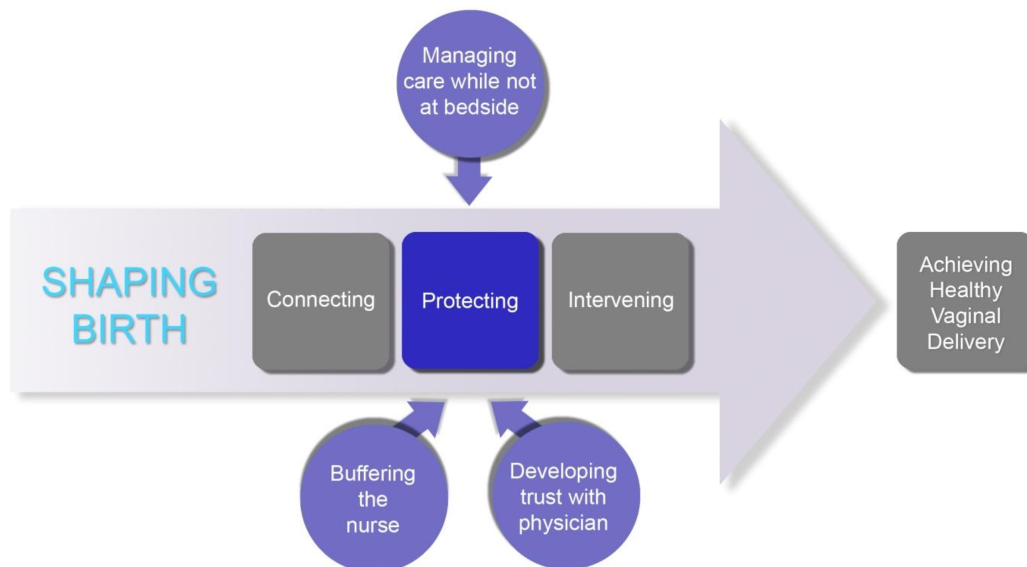


Figure 17: Protecting: The second step in Shaping Birth

Once a relationship has been formed between the CNM and her patient, she will often go to great lengths to achieve the desires of her patients. The in-hospital environment can be compared to an industrial machine. It works most efficiently and cost effectively when patients treatment is repetitive and similar. Like train cars moving down the same track over and over again, the hospital system tries to establish uniformity in treatment through protocols, systems management, control of the environment, and standardizing care by hospital staff. In order to meet the individualized needs of her patients, the CNM will often have to protect her patient from receiving standardized care by working to modify many of the controls of the system. *"We have some standard things that always happen to patients in labor. And it really is a fight to make them not happen."* (Kim, section 30) The CNM may use both aggressive and passive-aggressive techniques in order to change the course of the care of her patients.

I hate to hear that people are railroaded, and they are being railroaded… We'll induce you, then it won't work, then we'll section you…And even when you have a great relationship with the doctor, I still protect them from even him…I've just learned what not to say sometimes. (I) just don't sometimes tell the doctor everything, if I think I need a little more time or I can fix this or something. (Carol, section 56)

So as soon as she gets to complete, we usually do a trial of pushing, especially if she has an epidural. If she pushes well, we'll keep pushing, and if she doesn't, I'll let her labor down for an hour because again, it depends on the resident, but usually, that three hour mark is pretty firm, and if she hasn't made progress by three hours, you're going to call a section on a woman who's complete and the head is right there if they're still too high to vacuum. So you'll fudge a little, you'll say she's nine-and-a-half and she'll be nine-and-a-half for an hour or two hours, and then she'll be complete for an hour and you'll let her labor down for an hour and push for two hours and hopefully have a kid. (Kim, section 71)

In order to protect her patients from the inflexibility of standardized care if the patient has individual preferences that differ, the CNM will form relationships with the individuals in the hospital system and will work to maintain these relationships outside of their patient care situations. She talks and negotiates for care outside of the patient's room, all the while protecting the patient from being aware of these discussions, so that the patient is hidden from the power struggles which often occur in these encounters.

However, by hiding these discussions, the public is not aware of the extent that CNMs may have to go to in order to support the wishes of the patient. This is a form of audience segregation (Goffman, 1959) used by the nurse-midwife to prevent conflicts between the different roles she must take on in order to meet the needs of her patient.

> *I have a better rapport with them (residents)... But you try from the beginning to – it sounds terrible, but it's like midwife propaganda, (you tell them that) 'midwives at other places do this and we're taught to do this, and we're quite capable', and also you try to be helpful, you care for their patient if they're real busy because they remember that and whenever they come back as third years, they're like, oh yeah, she's competent and she doesn't need me to (intervene).* (Kim, section 91)

The CNM will also do the work of the nursing staff, taking on some of the nursing responsibilities for caring for the patient, as a way of getting specific activities to happen during the patient's care at a set time. These actions allow for the individualization of care for her patients. If the nurse-midwife directly provides the care, then she is able to control the type of care her patients' receive. Doing the work of the nurse also serves an additional purpose. The nurse-midwife is seeking to be seen as a helpful friend to the nursing staff and in this way help the nurse achieve her job responsibilities, thus decreasing the stress that she may feel while on the job. *"I love the nurses…But they're under a lot of time constraints and staffing issues and they've got policies. But they'll change things or they'll do it different if you're there to encourage them or help them."* (Carol, section 16) However, doing these activities also allows the CNM to meet her goals for patient management and this is done in an almost subversive

manner. As a friend, the nurse will often allow the nurse-midwife greater latitude in the variation of techniques she might use to assist patients in labor.

> *I am kind of trying to help the nurses… buffer that energy a little bit and create like a teamwork environment so we're all on the same team to really help this woman get her birth plan, get her perfect birth, whatever that may be…I'll start the IV, you get your paperwork, we'll do this together. So again, it's kind of a teamwork, we're all working together to get it done faster so this patient can do what she wants to, get her in the tub… I'm trying to do some of their work kind of a thing or helping them, helping the nurses and more allowing the woman to do her thing; so answering questions, kind of keeping things calm, trying to relate the patient's desires, that kind of thing, to the nurses.* (Irene, section 47)

> *I'll say, well, I'm going to go get your patient off the monitor and let her walk for an hour. And they're like, okay, because you're doing it. I think it takes some of the pressure off of them if we're here... And then on the other hand, when I was, if I was trying to speed somebody up and run Pit or whatever, and the nurses were too busy to do it, I'd go do it myself. So I'm just helping. And then the patient appreciates you being there.* (Carol, section 18)

Helping out the nursing staff provides dual benefits to the nurse-midwife. The CNM is able to control the type of care the patient receives and she is able to get positive

reactions from both the nurse and her patient, as she is visibly seen as being directly helpful to both.

The second phase of this model, protecting, consists of nurse-midwife creating an environment in which she is able to fulfill the goals of the patient. She creates relationships with the health care team members, so that open communication and mutual trust can be established. With this foundation, the nurse-midwife is able to request and alter standard plans of care, so that the individual needs and goals of her patient are able to be met.

Intervening.

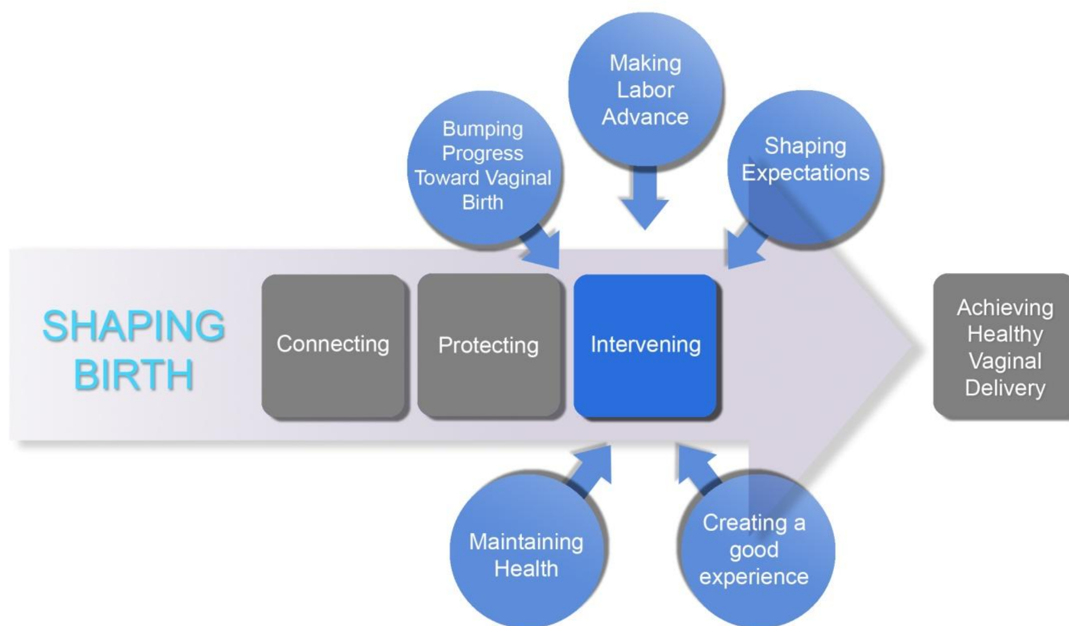


Figure 18: Intervening: The third step in Shaping Birth

The CNM implements intervention with the goal of achieving vaginal delivery. She uses multiple interventions throughout a patient's labor to accomplish several things: making labor a good experience for the patient, making labor progress, and achieving a vaginal delivery.

In one sense it's what you think is the best course to move labor on- because ultimately you want there to be a baby born healthy and the mom still to be healthy on the other side… (Intervention,) it's sort of like a bumper on the side of the path and you are like bumping them back into the path to keep them moving forward. It's not like you are on a track necessarily, like um that you are attached to one rail and you are moving along- it's like you are within (the boundaries of progressive labor). (Beth, section 94)

Beth uses the value laden term "healthy" in her discussion. Healthy is a term that I discussed in Chapter 2, whose definition is completely dependent upon the point of view of the person using the term. *"Intervention isn't necessarily bad when it's used appropriately or when it's used in a way that can be beneficial to your experience of birth and you're becoming a mother."* (Gale, section 80) Intervention in this context is often used by nurse-midwives with the goal of achieving a healthy birth, defined as good by her patients. This definition is used in contrast to that of a birth that is considered physiological, and proceeds without intervention. The nurse-midwives that I spoke with often favored physiological birth, but they also concurrently were able to define birth as both healthy and good even if intervention took place as long as no disease processes were present and the patient was able to achieve her personal goals. Intervention, as used in this context, has a broad definition. Nurse-midwives use intervention to describe anything they do to alter the flow of labor, from changing the patient's position, to ambulating, hydration, using a birthing ball, and using medical procedures such as

artificial rupture of membranes, oxytocin induction, medical forms of pain relief, up to and including cesarean birth.

During the interviews, nurse-midwives frequently discussed intervention in a way suggesting they were justifying their behavior. They spoke of using intervention for a specific purpose. *"I was very interventive with her because we needed to be moving toward delivery, she came in and I broke her water and we started pit, and she ended up doing great and we got a good baby out of it, but, that was the goal, and avoided a c-section for her."* (Beth, section 179) *"At a certain point you have to be like if you want a fair try at this vaginal birth thing, you have to kind of maybe have to give it a chance."* (Dorothy, section 122) These interventions are initiated with the participation of the patient in the decision-making process and instead of every patient receiving the intervention routinely, the selected intervention is used to move toward a specific goal, that of a vaginal delivery. However, including the patient in the decision-making process, specifically the type and timing of the intervention, has an additional goal. The CNM believes this will improve the patient's experience of labor and therefore the birth process. The nurse-midwife often uses very specific terminology at the level the patient can understand and lays the groundwork for these interventions throughout the patient's antenatal care and early labor. She is building upon the relationship she has developed with her patient, in order to communicate in a manner that is clear and understandable to her. The nurse-midwife is also selecting the intervention with an understanding of the patient's personal goals and expectations and then communicating in such a way that reflects her understanding of these personal goals. When working with patients whose goals for labor may differ from the plan of care the nurse-midwife is proposing, the

nurse-midwife must first be able to justify the intervention in terms of the patient's overriding purpose and expectations, which may be a vaginal delivery, or a birth without pain, or a birth that takes place with specific people present, or just avoiding a cesarean. In this manner, she is gradually shaping and sometimes re-shaping the patient's expectations about their birth. By spending the time to address the patient's expectations, her goal is to keep these expectations in alignment with her actual labor process, thus maximizing the potential for the patient to have a good birth experience. This desire for maximizing the patient's experience evolves out of the nurse-midwife's emotional connection to her patient and her goals for the patient. *"I feel like a failure if I can't produce a vaginal birth. And around here, in the hospital, it's about a 30% C-section rate and we used to have like a 15% C-section rate years ago and I like to keep mine under 20 and so every one that we do is a failure to me."* (Carol, section 48) The focus on the patient's experience of the labor process is a consistent goal, regardless of the outcome of the birth. Nurse-midwives contextualize the pregnancy and birth experience within the woman's entire life, recognizing the impact that it has on her self-identity and evolution as an individual. *"The most important thing to me would be that she felt honored and it was a good experience for her."*(Jill, 109) The nurse-midwives consistently stated that the definition of good was defined by the patient and not by them. Nurse-midwives focused on maintaining health in the process while achieving the patient defined outcome of a good birth. By allowing the patient to define what makes the birth good, the nurse-midwife is sharing and transferring control to her patients during their labor experiences. The transition of control, between the mother and the nurse-midwife via decision-making, education, and active participation, is the foundation for creating an

empowering experience as the basis for parenthood. This becomes the CNM's personal goal. *"I think it's real important that we remember that it's not just the moment of the labor and the birth, but that we do affect their entire life, I feel."* (Jill, section 112) The nurse-midwife recognizes the importance that this single experience can have on the woman's view of herself as an individual, as a parent, and as a partner (Halldorsdottir & Karlsdottir, 1996; Larkin, Begley, & Devane, 2007; Lavender, Walkinshaw, & Walton, 1999; Simkin, 1996).

> *(My goal is to have a) healthy baby, happy baby, happy mommy, healthy mommy, but I would like it to be a nice process along the way, the loving and joyful process for her.* (Dorothy, section 103-104)

> *My goal is for her to have as healthy a birth as she wishes for herself. That is the primary goal. Some people, and sometimes they focus on having vaginal birth, no matter what the outcome…especially if you see potential for problems. Then you want to redirect, nudge the person a little bit to realize what you're seeing as an important goal we may not realize it, and instead let's start looking at other options. What else in this process if we don't have that vaginal birth that would make it your birth? …A happy birth depends on how the mom perceives the birth and the outcome. You have a good baby; the baby's daddy is with mom, and a mom that had some idea of what she wanted starting off. And also coming to the conclusion that this, the time of birth or the birthing process was realized and I'm comfortable with that.* (Sue, section 64-66)

Intervening includes the actions of the nurse-midwife that are aimed at making her patient's labor into a good experience, making the labor progress and ultimately achieving a vaginal delivery. The interventions may be medical, such as those involving medication, implementation of technology, or pain relief. The interventions may also be used to support physiological processes, such as position changes, application of warm or cold packs for pain relief, and/or ambulation. The safety of the labor is integral to this step, along with the maintenance of a healthy birth process.

The goal: achieving a healthy, vaginal delivery.

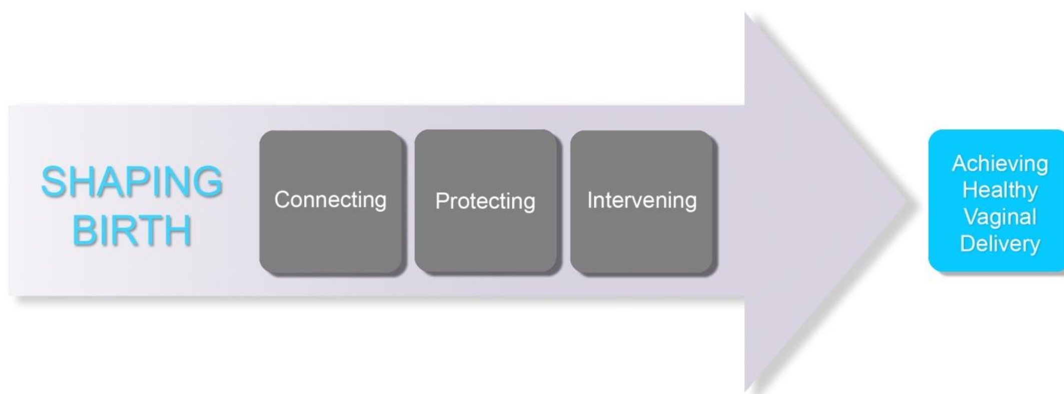


Figure 19: Achieving healthy vaginal delivery: the goal of Shaping Birth

The goal of the grounded theory of shaping birth is a healthy, vaginal delivery. The process of nurse-midwifery care has as its aim to achieve this goal. But how is this outcome achieved? To be effective at achieving specific outcomes, the nurse-midwife must create a level playing field in which all providers of health care are able to function maximally, yet are cognizant of the various goals each bring to the process.

Nurse-midwives often make connections between healthy processes and safe processes for her patients. These connections can be found in their terminology. *Healthy* is defined as a process where all safety and quality standards have been met and disease processes are absent.

A healthy baby, it just means that when you go into labor based on the information we have, we've done our ultrasound, we've done our lab work and everything is normal. You start the labor and you've got a category one strip normal. My goal is, I know we will deviate, I know that you could rupture her and you have meconium and the complications could be meconium aspiration. So when I'm delivering, you don't want to make a bad situation worse. So you want to deliver the baby and the patients want the baby on their chest right away. A lot of our midwifery patients want that, I want my baby, I want skin to skin, and that's fine. But if there's thick meconium, you're preparing her, this is what's going to happen, we have to, the baby there, sometimes the baby cries and we can put the baby there, but for the most part, the babies with meconium you want to get them assessed. So for me, in a case like that with a meconium baby, I don't want that baby to aspirate, sometimes it can't be helped. But my goal delivering is to get that baby delivered, get that baby over to the warmer so they can suck the baby out, especially if the baby is pale. That, to me, is a healthy baby. We've got good APGAR score, the baby is able to breast feed, the baby goes to regular nursery, the baby goes home with the mom. Another case would be a premature birth. You know the baby is compromised because it's a premature baby. So what's a healthy baby is that you're going to minimize any trauma to that baby as much as you can do. And that could be the lady is complete and she wants to push and you're like, let's not push, let's breathe through it and let the contraction

push that baby down so you're not pushing on that baby's head for hours; So whereas with another baby, we might push for two hours because she wants a vaginal birth. So a healthy baby is a baby that goes home with the mom, a baby who is not ending up in the special care nursery. And if it goes to special care nursery, it's just for a short time. So those are, like if I check all those off, then I've got a healthy baby. I've got a category one strip, and if I do get a category two, then we're acting on it and we're getting close to delivery. A category three strip, then we're doing a C-section. (Rachel, sections 107-110)

The health of the birth, the health of the mother, the health of the baby is an evolving definition to nurse-midwives. Nurse-midwives do not always equate a healthy birth with a physiological birth. Instead a healthy birth is specifically one in which the outcome meets quality and safety standards and disease processes did not exist. In this manner, a birth can be healthy even if intervention is present. A healthy labor also involves creating an experience for the patient that she is able to define as *good*.

Your baby looks good, your blood pressure is wonderful, we're getting your labs, let's at least monitor the baby, we've got rocking chairs, we've got balls, we've got everything in there. Yes, you can get in a tub and labor in a tub. No, we're not going to deliver in a tub, but yes, we can do that. So we're going to try to make this, as long as you stay healthy and as long as your baby stays happy, we'll do whatever you want to do. But we've got to get these bloods drawn, we've got to get an INT (Intravenous

access without flowing fluids), I like for my patients to have an INT, (but) it is not absolutely mandatory if she's totally against it. (Anne, section 26)

Another nurse-midwife defined healthy this way:

There should be something in-between normal and abnormal, you know, like its deviated from the expected path but um… I supposed then it does cease to be completely normal but it can still be healthy and satisfying to the mom and a good outcome and all that kind of thing… (Beth, section 32)

Beth is focused on fulfilling the wants and desires of her patient, even in a situation where labor may have deviated from normal and intervention may have been needed. Medical interventions, such as Oxytocin medication to increase the frequency and intensity of contractions, or epidurals to decrease the pain experienced by the patient and can allow for rest, will be frequently used by the nurse-midwife in the course of managing labor. Once these interventions have been instituted, the labor process has been altered in such a way that physiological processes no longer control the experience. Labor is no longer natural, if the definition of natural is limited to physiological processes. However, nurse-midwives maintain a belief that even with these interventions, labor can still be healthy. The nurse-midwife will use intervention to support labor processes that result in a progressive course, a vaginal delivery, and an experience the patient describes as good. To achieve an experience defined as good for her patient, the nurse-midwife must also connect with her patients and protect their wishes, and in this manner, maintain their agency. As long as these goals are possible and disease is not present, nurse-midwives will define labor as healthy.

Nurse-midwives in their dialogue will use the term *natural* to refer to physiologic birth processes. Physiological birth processes are those that occur spontaneously resulting in the birth of an infant without adding drugs or instituting interventions. Progressive natural processes and physiological processes are healthy, as their presence indicates the lack of disease in the process of labor, until proven otherwise. Healthy processes, while inclusive, are not limited exclusively to natural and physiological processes. Healthy processes are those in which our goals are able to be achieved during intrapartum and as defined by the nurse-midwifery process of care these include a progressive process, a vaginal birth and a good experience for the patient. To fulfill the goal of good experience, the nurse-midwife must actively work to discover her patient's needs and wants, but also support the power and agency of her patients. Nancy said that her role is to:

> *Make things more natural for the mom if we can and offer her what she would like… (to do) what she wants instead of having to (follow) the rules of the hospital…yeah, she's coming to the hospital, but let's make it more to what the moms want, if they want something different than just coming in and being in that bed and getting an epidural, offer options for them if they don't want that hospital type birth.* (Nancy, section 125)

The nurse-midwife is discussing the transfer of agency to her patient. In the hospital environment, often agency is possessed by those providing care to the admitted patient. Nurse-midwives will go against this norm, and actively seek to encourage the patient to maintain the agency during the course of her own labor. In this manner, care is individualized. Each patient comes to labor with their own habitus, resulting in different

needs and expectations. The nurse-midwife is specifically focusing on the needs of the individual, creating a relationship in which the patient is able to express these desires and creating an environment of care so that these desires can be supported and fulfilled. Pam described labor this way:

> *Labor is a normal, natural process and I'm going to be there with her through all of it, at least to some extent. And I'm going to try to tell her and provide to her all the information that I have or that I know to help her understand the process so that she feels like she's a key player and not just, didn't just present herself and let somebody else call all the shots.*
>
> (Pam, section 166)

Maintaining agency in women's labors is significant because a laboring woman is in a vulnerable state. She is in pain and embedded in a process that will result in two distinct and separate human beings. The process is physical, but it is also mental and emotional. Hospital based birth de facto removes agency from patients. Health care providers '*induce'* women, they *Pit* women, they '*epiduralize'* patients, they '*cut'* them, and they '*C-section'* patients. The language used by health care providers reinforces their status as active agents and thus have the power and control in their environment. When a nurse-midwife actively seeks to transfer that agency back to her patients, she is doing something that is outside of accepted routines in health care. This transfer of agency to the patient speaks to a unique difference in the way nurse-midwives provide care. This is an illustration of the application of what quality initiatives call patient-centered care.

Constructivist philosophical tenets agree with a belief in the inherent health of life, and that intervention should be aimed at the maintenance and support of healthy

processes, in a preventative manner whenever possible. The view of evaluating disease as a breakdown in singular parts of the human body does not correspond with a holistic view of people as cumulative sum of body, mind and spirit. In this manner, the bio-statistical model of health, with its focus on society and the view that health exists only as momentary victories in the battles against the forces that result in illness and death, does not serve the needs of individual patients. The salutogenic philosophy of health, changes this focus from a societal approach to an individual approach, allowing for the creation of particularized health goals that are provided for through action and the transfer of agency from the nurse-midwife to her patients via a process that promotes health as a normal, everyday state. This brings health back to the control of the patient, receiving the support of the nurse-midwife when needed, but still within their own agency and responsibility. Physiologic labor is accepted as healthy, requiring outside intervention only when disease processes are identified. Under these circumstances, intervention becomes the exception, as its use is applied only when indicated by the medical status of the patient, as based upon the tenets of EBPs. With the achievement of a healthy labor, the nurse-midwife is able to focus on the experience of labor for her patients. She can focus on supporting labor and birth with the patient maintaining agency, fulfilling her needs and expectations; and is thus good.

> *A healthy labor, to me, is a labor that is on (a progressive) labor curve. And at the end of it, there's minimum trauma to mom…emotionally and physically... intervention is just something I think that we do to get to the goal of a healthy baby. And it could mean that you have to give oxytocin. I don't have a problem with giving oxytocin if it's indicated in the labor.*

And unhealthy labor for me would be one where the woman is getting sick and we're not making progress, and if we don't act on that, it could be detrimental to both mom and baby. If somebody's ruptured, we've got meconium and the labor is just stretching out, we're not making progress, and they're refusing intervention, and to me, that's unhealthy labor because we're not doing anything. We are waiting for crisis to act. That, to me, would be an unhealthy one where we get to crisis before we're acting. And especially if we had the indications before and we didn't do anything… But if we see it coming, like… when you see the blood pressure is high and we're doing… even as simple a thing as changing positions to see if that would help,… sometimes just getting that epidural can help a little bit. So if we can do that, you can say "For pain relief, I know you want IV pain medicine, but your blood pressure is spiking and sometimes when you get an epidural, that tends to lower the blood pressure, so would you like to try that?" … You're the gatekeeper looking for all the things that could go bad, so that you can prevent them before they do… But if we can keep the complications out of the room, then it's a healthy one.

(Rachel, section 113-119)

EBPs and Shaping Birth: The Nurse-Midwifery Process of Care

The nurse-midwife values autonomy and responsibility, but she also values patient decision-making. The implementation of EBPs focuses on the use of the best evidence within a context that includes clinician expertise and patient preferences (Closs & Cheater, 1999; Institute of Medicine, 2001; Sacket et al., 1996). The implementation

of clinician expertise and patient preferences both reveal the agency of each individual. With nurse-midwifery care, the agency of the nurse-midwife must often be balanced or subservient to the agency of the patient. Often it is the undermining of the quality and/or safety of care, where the nurse-midwife will exert her agency over the patient's agency.

> *It was interesting because in this community what I've seen is the real, again, this almost like a division between natural birth, and 'they're not really midwives, they're med-wives' and blah, blah, blah, this type of thing. So a story happened, and I know you're probably going to think I'm insane but a story happened that made me go: How am I involved in the continuation of this? And the story was this, I had a former client who delivered her baby at the birth center, and she was telling me about a friend of hers from Rochester New York, and this friend of hers from Rochester was going to a licensed midwife and having a home birth. And her water broke, and she didn't do anything and the midwife had said you should go in the hospital and have a non-stress test and the woman didn't do anything. And suffice it to say after two-and-a-half days, she went into the hospital with a dead baby. And this girl was thinking about midwifery school and whether to become a CPM or an LM. And the story somehow really said to me what have we done? We've put natural birth over here, so that people feel like they have to defend themselves from medical birth. And how have I been part of that in this community? And that's when the shift came, when the wow, we could have this incredible healthcare where we could offer everything for women, everything, as long as they're*

> *educated. And that's when the shift came for me that natural child birth is fine, but women just need to be informed of things. Intervention isn't necessarily bad when it's used appropriately or when it's used in a way that can be beneficial to your experience of birth and you're becoming a mother.* (Gale, section 80)

In this study, I concentrated on the nurse-midwives' use of oxytocin, epidurals and cesarean section. Each of these practices has documented evidence specifying appropriate usage: ***oxytocin:*** (Albers, 1996; Alfirevic et al., 2009; Howarth & Botha, 2001; J. Martin et al., 2007; McCool & Simeone, 2002; Simpson & Poole; S. Tracy & Tracy, 2003; World Health Organization, 1997) ***medical pain relief including epidurals,*** (Anim-Somuah et al., 2005; Carvalho, 2006; McCool & Simeone, 2002; Nystedt et al., 2004; Poole, 2003; Torvaldsen et al., 2009; World Health Organization, 1997) and ***cesarean birth*** (Chaillet & Dumont, 2007; J. Martin et al., 2007; Maternity Center Association, April, 2004; McCool & Simeone, 2002; National Institute of Health, 2006; National Institutes of Health, 2006; NIH, 2006; S. Tracy & Tracy, 2003; S. K. Tracy et al., 2007; Viswanathan et al., March, 2006; World Health Organization, 1997; Young, 2007) The documented evidence allows for analysis of the implementation of these procedures by nurse-midwives. Specifically, I was interested how evidence plays a part in the nurse-midwife's decision-making, how she uses patient desires to influence her decision making and how her clinical experience with the use of these procedures plays a part in her decision making.

To explore patient preferences, the CNM must create a dialogue with her patient. This dialogue begins with the formation of a relationship with the patient. The nurse-

midwife must form an understanding of who the patient is and what she wants from her birth. Under ideal circumstances, this understanding evolves through the process of providing prenatal care. However, under some circumstances, the relationship must form quickly in the non-ideal circumstance of the patient experiencing labor in the hospital.

Nurse-midwives speak of making choices related to the use of these procedures on an individual basis. The evidence on each of these procedures states that their use should not be universal, but instead implemented only when the potential benefits outweigh their risk.

> *I think that these very well educated patients that we have coming into the practice that are very skeptical of what hospital birth has to offer, and rightfully so. I think they're aware of where the United States stands in the world on maternal and neonatal mortality, and they're not really that impressed with what we do. And so they come in and they ask good questions. They know that a lot of things we do are not evidence based. And they ask very good questions. And they care about making informed decisions. And so I think that's something that the group of midwives in this practice have really come a long way towards understanding that and altering our model of care to become more patient centered, more family centered.* (Tammy, Section 18)

Use of oxytocin for induction or augmentation by nurse-midwives.

Oxytocin medication, a synthetic of the natural hormone produced by women, is used to augment or induce labor. Oxytocin is the generic name for the medication often known by the brand name of Pitocin or in slang "pit". The goal in implementing the usage of this medication would be to start labor and/or make labor more efficient so that a vaginal delivery can occur or be expedited. Nurse-midwives reflect that when they make choices related to the use of this intervention, they respect the physiological labor as the goal for most labors, relegating the use of medication only when a medical indication is present.

> *I don't think women in labor are something that needs to be fixed. I think that it's a natural process…I think that they're better at (labor than we are using medicine. If) I've reached a point with my patient that it's (the natural process of labor is) broken, (then) you need to fix it (by using oxytocin). Otherwise, leave me alone and it's not broken and it will just progress to its end.* (Anne, section 104)

> *I will always say I will never do anything to you unless it's an emergency… At that point, again, hopefully, that trust has been established, so that way they know I'm going (to do) my best to tell them, educate them before doing it, but in the heat of the moment, it's being done. I try and give women options. You've been at six centimeters for six hours; I think we should break your water. But we could do it further out or I could start pitocin first, what do you want to do? And kind of*

based on what their previous experience has been, (we make the choice together)… I would say the first thing they teach us in midwifery school is to sit on our hands, not to muck around, but we can intervene when we need to. (Irene, sections 77-81)

These nurse-midwives are acting in a selective manner. They are describing a process that involves looking for a reason for intervention. Irene (along with several of the other nurse-midwives interviewed) discusses a process of preparing patients, through education and counseling, in advance of implementing intervention. In this manner, she is shaping her patients' expectations of the rest of their labor process. The process she describes involves maintaining the agency and power of her patients. She presents options and asks the opinion of her patient related to the plan of care. Through this process of transferring management power to the patient, the nurse-midwife is empowering them. She is also allowing the patient the time to accept the change in the way her labor is managed. In this way, she is giving the laboring woman the time to reshape her own goals and expectations of her labor. The CNM seeks to allow the laboring patient the ability to achieve a good labor experience. This process embodies EBP. The CNM uses her clinical expertise, patient input, and knowledge of research that supports the use of the intervention specifically for medically indicated reasons.

Some nurse-midwives feel strongly that oxytocin use is something that has become universal in women's labors. They seek to justify their usage of this medication for a specific medical indication every time they make the decision to order it. These statements exhibit the degree that nurse-midwives seek to verify their own management choices related to this intervention.

I will say that we use it sometimes when maybe we don't need to. But it's because of the flavor of society that a woman's water shouldn't be broke for more than 48 hours max, that you need to get labor going, that we use it so much with inductions. I don't think it's a bad thing, but sometimes I think if we would have left the woman alone, eventually she would have accomplished this birth on her own. But it's just the society that we're in, makes us feel like we have to at least do something to get this moving along. (Pam, section 142)

I think for me…that if it's done just routinely on everyone without a reason… then that makes it… less justified to me. It just makes sense to me that you do something that you have some reason you need to do it, not because… everyone has it done… (I use Oxytocin) because I had a reason to give her a bumper to get her back in the path (of progressive labor). (Beth, sections 156-158)

This theme of using intervention to bump labor back into the middle of an advancing stream was used by many nurse-midwives. They visualized their actions as being present along a wide continuum of options and reflected that there was wide variation within the realm of labor. They often would describe their roles as bumper cars along the edge of a road, as laborers alongside a stream, or as workers beside a conveyor belt, all with the purpose of nudging labor to exist within a wide path of labor variation that culminates in a vaginal delivery. Their goals were focused on getting labor to progress towards and then achieve a vaginal delivery, but they were also focused on

maximizing the experience for the woman in labor. These dual purposes might conflict, but it was the intersection of the evidence, the patient's opinion, and the nurse-midwife's experience that would result in the final management process.

Use of pain relief in labor by nurse-midwives.

The nurse-midwife is also seeks to justify each order when making a choice about pain medication and epidural usage. However, when these decisions are made, the nurse-midwife will often value patient desires as the strongest indication for intervention.

> *I always try to look at the big picture, like what kind of patient are we working with? Some patients will come in kind of decided that they want an epidural... I am not making the decision for her, I'm making it with her is the best thing I can do. It's a kind of informed consent, they can either do it this way, and these are the risk and benefits... allowing her to choose which way to go, and that's actually the best way to do it.* (Dorothy, section 122)

Dorothy lays out her process of working through management decisions with her patients. Through a process of integrating her clinical experience and research-based knowledge, she talks through these choices with her patients. In this exchange of information, she is shifting the management power to her patient. The goal of this shift is to maximize her patient's experience of labor. She acknowledges that patients enter labor with different needs and expectations and that these will ultimately influence the experience of labor and thus her management of labor. Dorothy acknowledges that labor management is "best" when the patient is significantly involved in the decision making process. It is important to note, however, that this is only achievable when the nurse-

midwife and patient have previously developed a relationship within a supportive environment.

> *(The patient) wanted natural labor and she came in with a doula and she labored and labored and she didn't make progress, and in the end we had to go against what she wanted, what she'd planned in her birth, (because what) she needed was an epidural, so she could get some rest because she was exhausted… (But) I was disappointed in that birth because I was disappointed that what she really wanted, we weren't able to achieve that. But by the time we got that point, she had resigned herself that we needed to do a little bit more, just for her to get to the end. But it was still kind of a disappointing thing for me because the patients, when they come with a birth plan, you want to stick to it as much as possible.* (Rachel, section 36)

The nurse-midwife must deal with a very difficult choice when she is confronted with the decision to intervene in a manner that may not be supportive of the patient's desires but supports a healthy, vaginal delivery. Even though the nurse-midwife is able to use her clinical expertise and the evidence related to implementing the epidural to support a vaginal delivery, the nurse-midwife remains concentrated on the patient's participation in the process. The nurse-midwife wishes to support the patient's desires. However, she understands the need for managing the labor in a way that conflicts with this desire. The ramification of this choice is evident through her stated feelings of failing her patient. The connection to her patient comes from the relationship and emotional bond that she created during implementing the first step in the nurse-midwifery process. It was this connection that allowed the nurse-midwife to work with this woman

so closely over long periods of time and reinforces her desire to make the process as good as possible for the woman in labor. The nurse-midwife desired very strongly to support the agency of the patient. In the end, the nurse-midwife had to reclaim agency, and in doing so, accepted negative emotional ramifications in order to support the ultimate goal of achieving a vaginal delivery. Readers can see from the previous textual example, Rachel makes a point of how important the patient experience of labor is to her and to her management.

With this example, Rachel also highlights a situation where the process of *Shaping Birth* was not wholly implemented and resulted in negative emotional ramifications for both the nurse-midwife and her patient. While EBP was implemented and the other aspects of *Shaping Birth* were supported in this description of care, the nurse-midwife described a situation where she was not able to allow the patient to maintain her preferred choice of pain relief. This choice was shaped by the nurse-midwife's ultimate desire to achieve a progressive labor process that results in healthy, vaginal delivery. This goal superseded the other steps in the process. When the labor starts to exhibit characteristics that lead the nurse-midwife into suspecting that a healthy, vaginal delivery is not achievable, the nurse-midwife will seek to implement interventions to "bump" the process of labor back toward the path that will result in this. When it becomes obvious to the nurse-midwife that this goal is not achievable, then she confronts the decision to move toward preparation for cesarean birth.

Cesarean use by nurse-midwives.

While the process of independently performing a cesarean is outside the scope of nurse-midwifery care, nurse-midwives are integral to the process of making the decision

as to when this intervention is necessary. When the goal of achieving a healthy, vaginal delivery is not achievable, the nurse-midwife is confronted with the decision to engage her team for achieving a birth via a different procedure. The nurse-midwife maintains a focus on maximizing the health, safety and quality of labor. These values and beliefs shape the process she implements when managing birth. Gale described this situation:

(I have a patient who is) laboring and she's kind of quietly doing her thing and she's five centimeters for a couple of hours and not really progressing much and she has, I'm auscultating and she has this decel (fetal heart rate deceleration), I put her back in bed and put her on the monitor and the strip looks fine and talk to her about, you know I think it might be a good idea for us to rupture membranes, you need to get into the next kind of stage, you're comfortable here and blah, blah, blah. So I put my hands in to do an exam and I feel something… it was a vasa previa, a vessel (that) goes across her cervix…. So I proceed to say to them look, you guys, we have a little bit of an emergency here and something that could be potentially really adverse to your baby... I call my backup physician, who basically says "you get them to do a C-section, we're not not doing (avoiding) a C-section. If you think you feel a vasa previa, we've got to do a C-section." It was a disaster. I mean, they eventually had a C-section. (Gale, section 86)

Gale was responsible for determining the need to have the cesarean and for discussing this with the patient and enlisting their support in the plan of care. Her physician delegated both of these responsibilities to her as the primary provider in charge of this patient's labor. Gale took on the responsibility to deal with both the change in goal and the change in the patient's desires. These alterations resulted in significant emotional ramifications as evident by Gale's description of the situation as a *disaster*.

However, Gale also noted that the safety of the experience for both the mother and the baby was her primary goal. Gale had to choose between continuing on the current plan and accepting significant increased risk for the infant and the mother, or deviating from the current path, accepting an experience that did not fulfill the patient's needs or labor goals but the choice most likely to maintain safety for the mother and the baby. The relationship Gale formed with her patient, allowed for the development of trust and respect which lead to the patient accepting and agreeing to the alteration in the management plan. Regardless, the nurse-midwife did not make this decision without acknowledging the evidence and safety issues inherent in these plans.

The nurse-midwifery process of *Shaping Birth* is focused around the goal of achieving a healthy, vaginal delivery. However, when the health of the patients, safety or quality of birth necessitates a change in the mode of delivery, the previous steps in this process continue to support management that ultimately reflects EBP. The actions of nurse-midwifery care seek to accomplish a healthy, vaginal delivery, but this is not always achievable. There are circumstances, based upon maintaining the health, safety, and quality of the birth experience, that necessitate management choices that conflict with this goal. Nurse-midwives often find themselves in the position of having to make a choice between supporting the wishes of her patient, the desires of the physicians and nurses that she works with, the protocols of the hospital and her personal desires for her patient's labors. Frequently, her choice involves placing the priority of one of these issues over the others. In these circumstances, she may not make the same choice each time, even if the situations are similar. The values and beliefs of nurse-midwifery practice ultimately influence the totality of the implementation of this process. The

nurse-midwife will continue to implement the other steps in the process. Those actions will provide the foundation for the nurse-midwife to shape her patient's expectations, the environment of care, and the actions of her team members in order to support the healthiest and safest possible outcome.

Moving away from the goal of a vaginal delivery may result in the nurse-midwife accepting some degree of negative psychological or emotional turmoil. Often this occurs when the nurse-midwife is aware that the desires of the patient conflict with this management plan. But typically, the nurse-midwife is willing to accept personal psychological stressors as long as the health and safety of her patient is supported. Possibly, these daily stressors potentially trigger significant negative emotional and physical effects for obstetric care providers over the long term, but that is beyond the scope of this research.

Chapter 5: Discussion

The current study reveals a new theory of contemporary nurse-midwifery practice. *Shaping Birth* provides new insights into the complex process of nurse-midwifery care that emerged from the experiences of contemporary, practicing nurse-midwives. This study is a first step toward gaining an understanding of how EBPs are implemented by health care providers in the management of labor and birth.

The theory of *Shaping Birth* is important in several specific ways. First, it begins to explain a complex process of care as implemented by nurse-midwives in the southeastern United States, where the rates of intervention in birth are elevated. As a profession, nurse-midwifery is uniquely situated in this environment at the apex between care provision and care management. Nurse-midwives both manage and provide direct patient care. The discovered process of care, as supported by the revealed values and beliefs, indicate that the nurse-midwives participants practice in manner that aligns with the implementation of EBPs. Because of this and their close relationships with their patients, I have argued that nurse-midwives approach birth management with a salutogenic philosophical approach. The salutogenic definition of health states health is present when you are able to achieve your goals (Antonovsky, 1979). Nurse-midwives work to support their patients in their desire to achieve a healthy, vaginal delivery. This focus on healthy processes and outcomes, allows nurse-midwives to individualize care and intervention, thus reducing the overuse, misuse, and underuse of our health care resources. In this manner, these nurse-midwives work toward improving the quality and safety of birth in their community.

The nurse-midwifery process of care, *Shaping Birth*, starts with fostering a relationship with patients to allow for a level of connection that results in rewards for both the patient and the provider. These feelings of satisfaction result in a positive feedback loop, which reinforces the continuation of the relationship for both individuals involved. This is the foundation for mutual understanding between providers and their patients. The CNM is able to discover the patient's desires, needs, and goals and the patient is able to develop trust in her provider. This relationship ultimately promotes open communication, so that the CNM is able to assess for knowledge deficits and explore options with the patient that support her goals, a healthy experience, and her safety.

The methodologies used were integral to the creation of the knowledge throughout this study. As a methodology, constructivist grounded theory provided specific benefits. This methodology allowed for the creation of a space of shared knowledge between the researcher and the participant. This space of shared knowledge was able to break down walls that would have resulted in rout answers representative of professionally expected replies. This space allowed for the culture of nurse-midwifery to be explored and described in a unique manner. This theory was inductive in origin, building from the native knowledge of the 19 individuals who shared their wisdom with me. This study highlights the first time that the voices of nurse-midwives embedded in hospital practice are used to construct rich descriptions of the current clinical practice of nurse-midwifery. Unique insights into the habitus of nurse-midwives are highlighted and an appreciation of the complexities of this health care profession can be achieved.

Situational analysis was used to create an expansive description of the field of nurse-midwifery care, thus providing depth to the context of the theory. The context of the theory must be accessible to those who desire to understand and implement insights from Shaping Birth. Congruence between the context the theory emerged from and the context of any application environments must be evaluated prior to generalizing the theoretical outcome. As a result, adding situational analysis to this study was a critical step in maximizing the usefulness of this theory. Situational analysis was used to provide depth to the field description of nurse-midwifery care and thus provides the tools needed for broader application of the theory beyond the context from which it emerged.

The process of discourse analysis allowed for exposing the habitus of nurse-midwives in a unique manner. Individuals in nurse-midwifery are confronted with value and belief statements throughout their professional lives. These statements exist in school texts, in organizational statements, in practice guidelines, and in hospital protocols. Hearing these statements over and over, embed these ideas in your psyche. However, this embedding may or may not position these ideas as integral to the nurse-midwife's habitus. Discourse analysis provided the tools to reveal the habitus of the life worlds of the nurse-midwives interviewed for this study. Through the use of discourse analysis, a new understanding was obtained. The participant nurse-midwives revealed, through their language, word connections, and genre chains, that they value the relationship with their patients above any specific management mandate. The relationship with their patients is the groundwork for supporting patient choice and empowerment in the management of their labor. The nurse-midwife works to support patient choice above any personally held beliefs about labor management. The patient

possesses the power and agency in this relationship and is able to define the goals for labor management. The nurse-midwife maintains the safety, quality, and health of the labor experience, but in doing so, she works at the bedside and away from the bedside to create an environment supportive of individualizing labor processes.

Implementing *Shaping Birth* through Embodying Leadership

Perhaps unconsciously, perhaps not, the nurse-midwife who shapes birth demonstrates several forms of leadership. The implementation of leadership skills is an important component of the national campaign to broaden the use of EBPs (Institute of Medicine, 2001). The use of leadership skills is integral to the creation of effective health care teams. Team leaders bring people together, assist in the definition of the vision or define the problem, and create the environment that supports team members maximizing their skills toward the combined goal (Ransom et al., 2008). The techniques used by leaders will influence the quality and effectiveness of the team actions.

Nurse-midwives will implement characteristics of servant leadership, especially with their patients, in order to meet their mutual labor and birth goals. Servant leadership is an approach that involves putting others first, empowering them and supporting them to develop to their full potential (Northouse, 2013). This process involves a shifting of power from the institution to those who typically have less power. This allows for the followers to develop interdependence, respect, trust and individual growth. Servant leaders will listen, provide empathy, support the personal well-being of others, be aware of the emotional, physical, social and political environment, provide gentle persuasion, be a visionary and conceive of how to implement the vision, possess foresight, provide stewardship, have a commitment to the individual growth of each person, and build a

safe, connected community (Northouse, 2013). Using these techniques, the nurse-midwife is able to fill in her patient's knowledge gaps in a way her patient is able to understand, whether she is a college graduate or someone with an elementary reading level. The nurse-midwife's goal is to allow the patient to have a good labor experience. Through the experience of labor and birth, the nurse-midwife is empowering her patients to feel a sense of accomplishment. This sense of accomplishment can morph into magnified inner strength that the patient is able to draw from throughout the days and years ahead.

Nurse-midwives who are embodying the characteristics of servant leaders use these techniques to motivate action. The nurse-midwife will treat those around her as colleagues. Through forming these relationships, she is able to discern each person's individual priorities. She will assist them in achieving their goals and encourage their participation in problem solving and decision making. Then she will share the emotional rewards that come from achieving these goals.

The CNM is motivated to move beyond the immediate provision of care to the development of relationships with other members of the health care team. The nurse-midwife must work outside of the patient/provider relationship to create an environment of care. She fosters relationships with nurses, physicians, and other health care staff members to establish open communication and trust. This involves the creation of health care teams around the practice of nurse-midwifery. These teams allow her to function 'outside of the box' while maintaining a safety net. In this way, the nurse-midwife uses characteristics of servant leadership to motivate and encourage her team members in their provision of care.

Another leadership form, transformational leadership, is characterized by a leader engaging and connecting with others with the goal of raising motivation and morality (Northouse, 2013). Transformational leaders concern themselves with the emotions, values, ethics, standards and goals of their followers in order to discover their motives, identify their needs and treat them as respected human beings. Nurse-midwives engage in the lives of those around them, in order to create the relationships that support their role as a transformational leader. We have seen how the CNM often will seek to implement changes in the routine practice of obstetrics. She looks for options to support her patient's needs and goals, involving the nursing and medical staff in these 'problem solving' sessions. Transformational leaders encourage their followers to actively participate in the decision making process, and in this way; the followers are often able to collectively accomplish goals far above expectations (Northouse, 2013, pp. 185-186). The nurse-midwives in this study used these strategies to inspire and motivate change in the routine plan of care so that they were able to meet the needs and goals of their patients.

Transformational leaders are identified by four specific characteristics: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Northouse, 2013). Nurse-midwives, when functioning as a transformational leader, are able to become *social architects* of labor and birth in the hospitals, leading to greater implementation of EBPs in their institutions.

Idealized influence refers to leaders who possess such charisma that they can motivate their followers to achieve and maintain high standards of moral and ethical conduct. They are trusted and respected. They put forth a vision and lead a mission to

fulfill that vision (Northouse, 2013). We have seen that nurse-midwives work closely with their patients and their colleagues in order to develop close relationships. Through this relationship, nurse-midwives share their vision for labor and birth and motivate their patients, nursing staff and backup physicians to support this vision. Carol described her motivation of the nurses this way: *"I love the nurses… they'll change things or they'll do it different if you're there to encourage them or help them"* (Carol, section 16). This motivation works because the nurse-midwife has gained the respect of those she is working with. She has to set an example for change through her own behavior and leadership.

The second characteristic of transformational leadership is inspirational motivation. Leaders must communicate high standards and follow through by inspiring a shared vision. They must motivate others to commit to this vision. Leaders will often use encouraging words and pep talks to create a sense of a team spirit (Northouse, 2013). Nurse-midwives use these techniques with both patients and staff. They use the word "we" in discussing activities, signifying collective action and that no one functions in isolation. The use of "we" also allows the nurse-midwife to reinforce their relationship with their patient or colleague. It allows for a shared vision and the creation of a shared plan to implement that vision.

Intellectual stimulation relates to problem solving with creative and innovative solutions. When she is encouraging patient participation in decision making or corresponding with the nursing staff or her supporting physician, the nurse-midwife is requesting problem solving. She openly accepts various points of view and is willing to look at the situation from a variety of ways.

The fourth characteristic is individualized consideration. This involves the creation of a supportive climate in which individual needs can be openly discussed. Dealing with each person on a one-on-one basis and individualizing care is integral to this concept.

Together these characteristics reflect an individual who is able to shape their environment by creating a clear vision, being a strong role model and empowering others. The nurse-midwife, functioning as a transformational leader, is able to trigger a change in obstetric care, resulting in the ability to individualize her actions. The relationships she forms with others through these techniques support mutual trust and a desire to help each other, so that when the CNM makes a request to alter the expected plan of care, she is given the benefit of the doubt. The nurse-midwife is rewarded through this process by the people she works with feeling better about themselves and a gaining a sense of accomplishment.

Nurse-midwives must be comfortable with and know their own identity if they are to function as leaders enacting the nurse-midwifery model of care. This identity is both contextually and relationally defined. The context is grounded in the history of the profession which began with the simple accompaniment of women and families, but now involves relations with those that surround her, in the highly, technically sophisticated environments of the contemporary hospital. She must confront historical images of herself as an ignorant, dirty, barefoot [interpreted as poor] attendant in home birth, to another extreme caricature of a white coated, highly trained interventionist. Nurse-midwives view physicians as partners or colleagues, but often practice structures place nurse-midwives as employees, structurally below physicians. Thus, often they are not

invited to participate in the management and decision making that oversees their practice. Nurse-midwives rarely influence the decisions articulated by those at the top of the hierarchy of the hospital environment; however the care they provide *is* influenced by decisions made by the upper echelon of the hospital. Through the creation of policy and architecture, the hospital administration possesses significant authority over nurse-midwifery practice. Nurse-Midwives also function in a unique position to nursing. At times, their role may involve determining nursing action, but often they function side-by-side with nursing, sharing direct patient care and in some circumstances, their role may even be subservient to nurses (whose role includes enforcing the rules and regulations of the hospital).

James Scott's theory of resistance (1985) can provide some insight into understanding how these women leverage their identity to create an environment that supports their practice. Scott views resistance as a routine action, not aimed at altering structures of inequality, but instead used to allow the lesser individual the capacity to act in pursuit of their own interests. (Scott, 1985) Nurse-midwives use this everyday *resistance* to work against the expected norms of labor and birth management in the hospital environment, in order to pursue the nurse-midwifery process of care. They want to focus on using intervention on an individual basis, on the patient's experience of labor and on achieving the outcome of a vaginal delivery. The nurse-midwives use their capital, as established by their relationship with their supporting physician, their relationships with hospital staff, and their relationships with their patients, to implement resistance on an ongoing basis. Through their unique position in the hospital environment, nurse-midwives are able to encourage and implement change.

Significance of the Implementation of *Shaping Birth*

The entire process of *Shaping Birth* has as its goal a healthy, vaginal birth. Health is contextually defined within the profession of nurse-midwifery. The nurse-midwife's definition of health reflects the view of salutogenesis- that health is the ability to achieve one's vital goals. This orientation- that health is something embodied by the whole of the individual- is one of nurse-midwifery's distinctive contributions to health care. Via a salutogenic orientation, patients are considered healthy when they are able to achieve their goals. When a patient is healthy, they have less need for medical intervention and medical assistance. EBP in the provision of maternity care involves the provision of effective care with the least harm (Sakala et al., 2008). Effective care fulfills the goals and expectations of the process of labor and birth and maintains a safe, quality experience for the mother and her infant. Salutogenesis supports EBP in maternity as the process and goals for each are remarkably similar. The process of both salutogenesis and EBP involves gaining an understanding of the goals of the patient and then supporting the patient through their achievement of these goals. In this manner, the salutogenic underpinnings of nurse-midwifery practice provide a strong foundation to the implementation of EBP in maternity care.

The theory of Shaping Birth supports the salutogenesis in several specific ways. When implemented, the theory of Shaping Birth is a blueprint for a salutogenic birth. Through connecting with patients, nurse-midwives create relationships that allow for open communication concerning the patient's individual goals and desires for her birth experience. This knowledge is critical, as the goal must first be defined in order to be acknowledged, planned for, and achieved. The second step involves the nurse-midwife

creating an environment of support for the patient's goals. Through forming relationships with other providers who have a significant impact upon the birth process, the nurse-midwife is able to use her power and influence earned through the creation of relationships of trust and respect, to alter routine processes to the specific processes that support the patient's individualized goals. In this manner, the nurse-midwife is also capable of decreasing intervention in birth, when she deems it appropriate. She is able to alter routine admission protocols, either by delaying or removing orders for specific interventions. Through this process of individualizing care, decreased routine medical interventions will result in decreased medical costs for our health care system. As a health care provider willing and capable of providing hands-on patient care, the nurse-midwife is also able to ease some of the responsibilities of the bedside nurse. In this manner, the nurse-midwife is capable of taking on some of the patient care responsibilities, allowing the nurse more time to fulfill her specific job required duties (such as charting, medication administration, and care coordination). Via intervening, the nurse-midwife is able to selectively choose actions to specifically achieve the patient's goals. This may be the use of ambulation in labor or it may involve ordering epidural pain relief. If the intervention aligns with the patient's goals for their labor, then the intervention is supported and health remains. The presence of an intervention in the birth process does not eliminate the health of the labor process, especially if the patient's goals for her birth remain supported.

As most births involve healthy women undergoing a healthy process, the process has the potential to be implemented in a broad manner. Each step of this process, while drawn from nurse-midwifery care, could be applied by all providers of obstetric services.

Though the steps emerged from studying nurse-midwives, other professions that work in obstetrics may find insights. The ability of a qualitative outcome to be generalizable in other contexts will be dependent upon the congruence between the original research's context and the area of application's context (Ritchie & Lewis, 2006). The values and beliefs of nurse-midwifery care do create the foundation, motivation, and positive feedback that supports this theory and recursively encourages its implementation. Other providers, who may not share the same habitus, will need to look at their beliefs and values in closer detail to observe how they align with this process. Through this self-awareness, other providers may be able to build a support system that encourages the creation of the personal relationships, the environment of protection and the concept of individualized intervention that supports a healthy, vaginal delivery. Other providers, without a congruent values and belief system, may still find insights and new approaches to EBP via Shaping Birth. The habitus and field of nurse-midwifery care as described in this study, serves as both positive and negative feedback to encourage the use of EBP by these nurse-midwives. Other streams of feedback, both positive and negative, will need to be explored for their influence on the theory in other contexts. Shaping Birth, when applied to other professions managing obstetric women in birth, should be used as a hypothesis or a preliminary extrapolation until it is proven or disproved by further evidence (Ritchie & Lewis, 2006). In this manner, the theory can provide guidance and insight into management processes of additional obstetric professionals that would broaden the implementation of EBPs.

The value of any qualitative research study is determined by its usefulness to scholars and clinicians. Usefulness of a grounded theory can be determined by the

theory's ability to explain, predict, or describe processes and/or behavior. The nurse-midwifery process of care explains how nurse-midwives implement EBP within the current complex health care system. Globally, midwives are recognized as significant and important clinical providers for birthing women. In the United States, multiple studies over many years have documented positive outcomes for nurse-midwifery care. However, in this age of expensive medical intervention in birth, there is a need to understand how nurse-midwives effectively implement the evidence based procedures that are necessary for the achievement of their documented outcomes. As the Affordable Care Act of 2010 is rolled out across the United States, health care reimbursement will be linked to achieving healthy outcomes for women and babies in birth. The model of nurse-midwifery care, which addresses how nurse-midwives manage care, provides insight to potential changes in obstetric care management by all providers in order to increase EBP and decrease maternal morbidity and mortality.

In the United States, we must learn to deal with the dichotomy that exists in our health care system. Most other industries minimize costs and maximize outcomes by unifying and streamlining tasks. However, health care is characterized by the goal of meeting the requirements of individuals, no two of which have identical desires or needs. The health care system must create a structure of care where individuality in management is cost-effective and easy to implement. Leaders must emerge from our current system to model and support the changes that are required during this time of evolution.

The model of *Shaping Birth* has emerged from interviews with nurse-midwives in a specific geographic region of the United States. The nurse-midwives, whose ideas and thoughts provided the material for analysis, may not be assumed to characterize other

nurse-midwives or have similar experiences to other obstetric providers. However, their experiences are likely to resonate to a greater or lesser degree in other geographic regions and with other obstetric providers. The critical relationship between obstetric managers of birth and nurses providing direct care in labor and delivery should be recognized. As the care provider that is monitoring and caring for the laboring women in hospitals, recognition of their important role and influence on outcomes of care needs to be acknowledged by those managing that care. Significant amounts of nursing practice revolve around coordinating care for the patients they work with. Care coordination is one of IOM's 20 national priorities to concentrate on in order to transform the health care system (Institute of Medicine, 2003). This care coordination is often invisible within the context of our current health care system (Lamb, 2009). As providers who are dependent upon this care coordination, nurse-midwives can both support and learn from the care coordination expertise of the nurses they work with. In this manner, the health care providers can work together effectively, implementing EBP supported by effective care coordination and teamwork.

Partial implementation of *Shaping Birth*

As a nurse-midwife provides care according to the process of *Shaping Birth*, there are moments when she may move away from the main path of the process. Circumstances may create situations where she may not be able to create a relationship with her patient (such as a patient without prenatal care being admitted to the hospital and immediately delivering) or she not be able to make labor a good experience for her patient (as in the situation of the patient who desired a physiologic birth and experienced medical complications requiring intervention) or the birth may take place via a cesarean

instead of by vaginal delivery. This does not necessarily diminish the work that the nurse-midwife accomplishes in the other process steps. Patient care is not always linear. Sometimes, for reasons of quality and safety or patient desire, the nurse-midwife may need to implement intervention without evidence based indications. The labor and delivery unit in the hospital is a rapidly changing environment. One moment all patient care is routine and in the next moment, multiple medical interventions are required. The ability to rapidly modify plans and adapt to changing needs is skill required by obstetric health care providers and for any theoretical model whose goal is to explain, predict, or describe care. The process of *Shaping Birth* can be implemented in total or in partial and may still have the power to support transformative and empowering birth experiences for women. The testing of the model in clinical situations would be a next step in assessing the validity of the model's ability to explain nurse-midwifery care.

Implementation of *Shaping Birth* Supports EBP in Birth

Shaping Birth does support EBP in significant ways. EBP requires the merging of clinician expertise with patient desires and the latest research based evidence. All three components of EBP are integral to the values and beliefs of the nurse-midwives who were interviewed during the course of this research. The interviewed nurse-midwives held concurrent respect for avoiding intervention through the support of natural processes and practicing within the realm of advanced medical health care, using technology and medical intervention. The intersection between these two discursive beliefs is where some of the most interesting aspects of the nurse-midwifery process are occurring. The nurse-midwives in this study have embraced both of these values. The choices between these two views of care occur in their practice in an ongoing manner. Nurse-midwifery,

today, is bridging the non-interventionist extreme of physiological birth with the intervention-heavy medical management of birth that occurs within the context of our current health care system. Through the process of *Shaping Birth*, nurse-midwives are directing their care, not exclusively at the outcome of birth, but also on the experience of birth. This different approach allows them to look at what is actually taking place in the labor room and places them in the position to reflect on their behavior as either adding or subtracting from the experience of birth for their patients. As a result, interventions are recommended only when they add to the patient's experience or they are needed for the purpose of safety, or they significantly encourage the outcome of a healthy, vaginal delivery.

Future Steps

This study is a beginning step into evaluating the current status of obstetric care in the United States. Further knowledge is needed for us to understand the complexity that influences the management of women during labor and birth. This theory remains in its infancy. Additional study and evaluation needs to look at the variety of ways nurse-midwives practice in other parts of the United States. Rates of intervention and birth outcomes do vary depending upon demographic profiles. The process of nurse-midwifery care will need to continue to be explored to reflect the multitude of care processes used in other US localities. To expand the theory development, this study would need to be replicated in other regions where obstetric care may be influenced by a different field, capital and habitus. In this manner, the theory would be supported or expanded further to provide greater depth and understanding concerning the processes nurse-midwives use to implement EBPs.

In addition, the processes of care of physicians and nurses need to be evaluated, especially how these processes interact with and change in response to the nurse-midwifery process of care. The technique for evaluating the processes of care of physicians and nurses would be very similar to the process implemented in this study. Techniques of ethnography and participant observation may add further insights and depth to the discovery of the process of care within these provider groups.

While each of these areas of analysis are important to the support and expansion of the knowledge discovered in this research, my next focus will be specifically on expanding the depth of the situational analysis and discourse analysis described in this research. This would involve a process aimed at revealing the weight of the influence of each of the field factors on the process of Shaping Birth. By going into additional depth in this area, my goal would be to uncover specific factors that have a substantial influence on the provision of EBP in birth management. Situational analysis allows for framing a meso-level interpretation of the situation present in nurse-midwifery birth management (Clarke, 2005). Through the use of positional maps, a nuanced understanding of the different positions embodied by the key factors affecting nurse-midwifery care can be revealed. This additional knowledge would support the creation of intervention studies focusing on improving the use of EBP by positively affecting key factors.

Through a process of expanding the depth of the discourse analysis in this research, my goal would be to uncover the location and transfers of power between individuals in the labor and delivery unit. Using techniques from the linguistic anthropology toolbox (Fairclough, 2003), I would focus in on utterance structure to reveal more detail within the themes embedded within the talk. This process would

include the analysis of pronouns (such as I, we, she) used in the data in association with actions in order to reveal who possesses the agency at different times during care management and under what circumstances that agency transferred between individuals. This information would shed light on the actual functioning of the health care team (this team is inclusive of all the individuals with affect on the process of care including, but not limited to the patient, her family members, the nurse-midwife, the nurse, the physician, and other health care providers). With detailed analysis of the functioning of the health care team, the role of leadership (Northouse, 2013), and the application of macrocognition (high level cognitive thinking) within teams (Letsky & Warner, 2008), greater understanding of the multifaceted process of care management can be obtained. With this understanding, techniques can be developed to specifically address issues to improve the quality and safety of birth in the United States, in which, despite all of our resources, 1 in 3 women will experience complications adversely affecting their health (Amnesty International, 2010).

In this manner, the real benefits of this study will come to light. If, with further exploration, this theory can be linked techniques that when implemented can increase the use of EBP, not only by CNMs, but also by obstetric team members, then the current study's outcome will provide the foundation for improving obstetric health care for all.

> *I see that nurse midwives can bring about subtle change. I have a friend that is the only midwife in a hospital and… she brings in different ways of doing things that people would not have considered… (Nurse-midwives are) a voice, almost this lone voice… of "wait a second, it doesn't need to be done this way, there's another way we could be doing things that*

perhaps would give us better outcome than we have"... I think that nurse-midwifery has a huge role to play, in terms of being a voice that's not always heard in healthcare. (Gale, section 24)

Appendix 1: IRB Approval

TO: MaryJane Lewitt, CNM, MN
Principal Investigator

DATE: November 11, 2010

RE: *Notification of Exempt Determination*
IRB00047736
Nurse-Midwifery in the Hospital Setting: Exploring Evidence Based Practice

Thank you for submitting an application in eIRB. We reviewed the application and determined on 11/11/2010 that it meets the criteria for exemption under 45 CFR 46.101(b)(2) and thus is exempt from further IRB review.

This determination is good indefinitely unless something changes substantively in the project that affects our analysis. The PI is responsible for contacting the IRB for clarification about any substantive changes in the project. Therefore, please do notify us if you plan to:

- Add a cohort of children to a survey or interview project, or to a study involving the observation of public behavior in which the investigators are participating.
- Change the study design so that the project no longer meets the exempt categories (e.g., adding a medical intervention or accessing identifiable and potentially damaging data)
- Make any other kind of change that does not appear in the list below.

Please do not notify us of the following kinds of changes:

- Change in personnel, except for the PI
- Change in location
- Change in number of subjects to be enrolled or age range for adults
- Changes in wording or formatting of data collection instruments that have no substantive impact on the study design.

For more information about the exemption categories, please see our Policies & Procedures at www.irb.emory.edu. In future correspondence about this study, please refer to the IRB file number, the name of the Principal Investigator, and the study title. Thank you.

Sincerely,

Carol Corkran, MPH, CIP
Senior Research Protocol Analyst
/This letter has been digitally signed/

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: http://www.irb.emory.edu/
/An equal opportunity, affirmative action university/

Appendix 2: ACNM Approval to Solicit Membership for Research Participation

Kerri D. Schuiling, PhD, CNM, NP-BC, FACNM
ACNM
8403 Colesvile Road Ste 1550
Silver Spring, MD
February 13, 2011

MaryJane Lewitt, CNM, MSN
1171 Lenox Circle NE
Atlanta, GA 30306

Dear Ms. Lewitt:

We have received your correspondence about your research study: *Nurse-Midwifery in the Hospital Setting: Exploring Evidence Based Practice,* and your request to access ACNM members for their participation in the study. Thank you for forwarding the pertinent documents to the ACNM office. The purpose in requesting these documents for the ACNM files is to ensure that the rights of ACNM members as research participants will be adequately safeguarded and that surveys mailed to ACNM members are pertinent to the midwifery profession and practice.

All of the relevant documents have been reviewed and your request is approved.

The general statement that is to be used in your letter or ad should be: "Solicitation of CNM/CM participants for this study has been approved by the ACNM".

Also included with this approval to access ACNM members mailing addresses please find 1) Rights of ACNM Members as Research Subjects, 2) contact information for our Director of Membership Services, George Hamilton. His email is ghamilton@acnm.org. George will assist you in setting up the email notification to members that you will use to send our members the link to your survey.

Good luck with your study! We look forward to seeing the results of your study.

Sincerely,

Kerri D Schuiling

Kerri D. Schuiling, PhD, CNM, NP-BC, FACNM
Sr. Staff Researcher
ACNM

Appendix 3: Demographic and Personal Information Form

Date:
Subject ID#:

Demographic and Personal Information Form

Age:________________________________ Gender: Female:_________Male:________________

What is your ethnic background? Hispanic or Latino?_____________ NonHispanic or Latino_________

How do you describe as your racial background? American Indian or Alaskan Native_____ Asian_______
Native Hawaiian or other Pacific Islander?_____Black or African American________ White________

What are your previous educational degrees /years?____

Where did you receive your education?____

In what year were you first certified as a nurse-midwife?_____________________________________

How many years have you worked in clinical practice? ______________________________________

Do you have previous experience in other practice locations? Y N

If yes, please list the cities, states of the previous practices?______________________________

In what city and state do you currently practice? ____

Please describe your practice location: Rural______ Suburban_______Urban_______ Inner-city_______

Who is your employer? Hospital________HMO__________Private physician practice____________

Other, please list____

How many nurse-midwives are in your practice? ____

What is the average number of hours you work in the office per week?__________________________

What is the average number of hours you are on-call per week?_________________________________

Are physicians, nurse-practitioners, or physician assistants affiliated with your practice? Y N

If yes, how many do you work with? MD__________ NP__________ PA___________

What level is the hospital that you deliver at? Level 1______ Level 2_______ Level 3________

How many births do you manage per year? ________________ or by month?_____________________

Please describe the approximate distribution of the practice population that you serve in terms of class?
Lower class_______%_Working class________%__Middle class_________%_Upper class_________%_

Please describe the approximate distribution of the practice population that you serve in terms of ethnic and racial background:
Hispanic or Latino?__________% + NonHispanic or Latino________% = 100%

American Indian or Alaskan Native_____% + Asian______% + Native Hawaiian or other Pacific Islander?_____ % + Black or African American_______ % + White________ % = 100%

Appendix 4: Participant Screening Form

Date:

Subject ID #:

Study of Nurse-Midwifery Practice
Participant Screening Form

Are you a Certified Nurse-Midwife?	Y	N
Do you perform deliveries in a hospital?	Y	N
Do you practice full-scope nurse-midwifery?	Y	N
Do you work full-time in this capacity?	Y	N
Are you comfortable talking and communicating in English?	Y	N
Do you have between 3 and 20 years of clinical experience?	Y	N
Do you personally know MaryJane Lewitt?	Y	N
Dr. Jennifer Foster?	Y	N
Dr. Gerri Lamb?	Y	N
Dr. Debra Spitulnik?	Y	N

Contact information for potential participants who choose to participate in the study:

Name:____

Address:____

Phone number:____

Email address:____

What is the best time and way to contact you?______________________

Appendix 5: IRB Approved Consent

Study No.:IRB00047736 | **Emory University IRB** IRB use only | Determined Exempt On: 11/11/2010

Emory University School of Nursing
Consent to be a Research Subject

Title: Nurse-Midwifery in the Hospital Setting

Principal Investigator: MaryJane Lewitt

Sponsor: Jennifer Foster, PhD

Funding Source: Sigma Theta Tau International- Alpha Epsilon Chapter

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. The decision participate or not participate in the research study will not result in any consequences. **Solicitation of CNM/CM participants for this study has been approved the ACNM.**

Purpose

I am asking you to take part in this research because you are a nurse-midwife who provides care in a hospital setting in the southeastern United States. Approximately 30 individuals will be interviewed for this research study. This study is being conducted for my dissertation under the direction of Dr. Jennifer Foster.

Procedures

If you agree to participate, I will interview you for about an hour at my campus office or a mutually agreed upon location. The questions will be about your perceptions of practicing nurse-midwifery in the hospital and the things that may impact your practice. I will audio record the interview, with your consent. These voice recordings will be transcribed and then be destroyed at the end of the data analysis.

Risks and Discomforts

There are no foreseeable risks associated with this study. However, you may experience discomfort as I will be asking you to describe situations when you perceive that your management of birth may not be ideal according to your beliefs and values.

Benefits

This study is not designed to benefit you directly. The information you provide, however, will add to our knowledge about the practice of nurse-midwifery and how nurse-midwives practice in the hospital setting. As a result, the results of this study may be used to help other people in the future. There may be no direct benefit to you as a participant from this study.

Compensation

You will not be offered payment for participating in this study.

Confidentiality

I will not include your name in study results. If you feel uncomfortable, quotations or narratives can be left out of the analysis at your discretion.

A study code rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results. All research records and audio recordings will be kept in a locked secure location.

Certain offices and people other than the researchers may look at your study records. Government agencies, Emory employees overseeing proper study conduct may look at your study records. These offices include the Emory Institutional Review Board, the Emory Office of Research Compliance, and the Emory Office for Clinical Research or the Office for Human Research Protections. Emory will keep any research records we produce private to the extent we are required to do so by law. Study records can be opened by court order or produced in response to a subpoena or a request for production of documents.

Costs

There are no anticipated costs to you from being in this study, other than the time you spend with me during the interview and any costs associated with your transportation to and from the location agreed upon for the interview.

Withdrawal from the Study

Participation in this research is voluntary. You may refuse to participate, or refuse to answer any questions that you do not want to answer. If you decide to be in this study and change your mind, you may withdraw at any time. Your participation or non-participation will have no negative repercussions.

Questions

Contact MaryJane Lewitt at 404-441-3190 or mlewitt@emory.edu:

- if you have any questions about this study or your part in it,
- if you have questions, concerns or complaints about the research.
- You may also contact my advisor, Dr. Jennifer Foster at Jennifer.Foster@emory.edu or 404-727-8445.

If you have questions about your rights as a research subject or if you have questions, concerns or complaints about the research, you may contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu.

Consent

I will give you a copy of this consent form to keep. Do not sign this consent form unless you have had a chance to ask questions and get answers that make sense to you.

Nothing in this form can make you give up any legal rights. By signing this form you will not give up any legal rights. You are free to take home an unsigned copy of this form and talk it over with family or friends.

Please sign below if you agree to participate in this study.

____
Name of Subject

____ ________________
Signature of Subject Date Time

____ ________________
Signature of Person Conducting Informed Consent Discussion Date Time

Appendix 6: Interview Guide

Interview Guide

Nurse-Midwifery in the Hospital Setting: Exploring Evidence Based Practice

Introduction:
Good morning, my name is MaryJane Lewitt and I am from Emory University. I am conducting a research study on the practice of nurse-midwifery in the hospital setting. This research is funded by Sigma Theta Tau Alpha Epsilon Chapter. As part of this project, I am talking to nurse-midwives who provided birth services in a hospital setting to get viewpoints on the values and beliefs you use in your practice. I am also interested in learning your perspectives about the various people and institutions that affect the care you provide. Through hearing your thoughts on these topics, I feel I can learn ways to improve the quality and safety of obstetric care in the United States. You have been selected to participate because of your experience and knowledge on the practice of nurse-midwifery in the hospital setting. Your participation in this interview is completely voluntary and you should feel free to not answer any question. You may also stop the interview at any time.

If it is OK with you, I would like to audio record our discussion as I cannot write as fast as we talk and I don't want to miss any of the issues we talk about. Our conversation is completely confidential- I will not use your name in any of the documents and none of the information that you provide will used in a manner that could result in your identification. Do you have any questions about this? Do I have your permission to audio record our discussion?

I have a list of topics that I would like for to talk about, but please feel free to mention any other ideas or areas that you feel are relevant. There are no right or wrong answers and I am most interested in your personal opinions, so please feel comfortable to say what you honestly feel. Shall we begin?

1) **Opening Questions**
   a) What motivated you to become a nurse-midwife?
      i) Probe-What was it about the profession that interested you?
      ii) What did you know about the profession before you got into it?
      iii) Why did you want to be a nurse-midwife?

   b) What things about your current practice made you want to work there?

   c) What is it like being a nurse-midwife working in a hospital setting?
      i) Probe: What is good about working in a hospital? And why?
      ii) What is difficult about working in a hospital? And why?

2) **Approach to care**

   Next, I am interested in learning about your usual approach to patient care in the hospital.

a) Talk me through a typical patient admission, labor and birth.
   i) Probe: What normally happens first? What do you ask? What do you say? Then, what do you do? What do you think about (or consider) when that happens? (focus on decision points)
   ii) Do other providers (e.g. physicians, nurses, and other staff) make a difference in your choices?
   iii) What part of the birth experience do you find the hardest to manage as a nurse midwife? Why?
   iv) What part of the birth experience do you enjoy the most? Why?

b) Describe one of your most satisfying (or fulfilling) births.
   i) Probe: What was it about this birth that you enjoyed so much?
   ii) What did this birth mean to you?

c) Describe, now, a contrasting birth that was not satisfying to you.
   i) Probe: What was it about this birth that made you unhappy?
   ii) What did this birth mean to you?

3) <u>Management issues in Birth</u>

Now, I would like to ask you about a few common management options that you may consider while taking care of patients during labor. I am interested in understanding how you make these choices and what influences the choices that you make. Please feel free to mention any ideas that you feel are relevant.

The first area is about the use of pitocin for induction or augmentation.

a) In what type of situations are you are more likely to use pitocin?
b) How often do you use pitocin?
c) How do others (physicians, patients, nurses, other staff) influence whether you use Pitocin or not?
d) What things do you consider (think about) when you choose to use pitocin?
   i) Probe: Why is that important?

The second area I would like to talk about is the use of medical pain relief, including epidurals, in labor.

a) What types of medical pain relief do you commonly order in labor?
   i) What people or things affect your choice between these options?
b) In what type of situations are you are more likely to order epidurals?
c) How often do you use epidurals?
d) How do others (physicians, patients, nurses, other staff) influence whether you order epidurals or not?
e) What things do you consider (think about) when you choose to order epidurals?
   i) Probe: Why is that important?

The final area that I would like to talk about is the decision to deliver a patient by cesarean.

a) Tell me about some of the common situations that lead to you to consider delivering a patient by cesarean.
b) How often do you find that you decide to deliver a patient by cesarean?
c) How do others (physicians, patients, nurses, other staff) influence whether you deliver a patient by cesarean or not?
d) What things do you consider (think about) when you decide to deliver a patient by cesarean?
    i) Probe: Why is that important?

2) <u>Ending questions</u>

Now, I would like to ask a few final questions about your care to women in the hospital.

a) If I were talking to a patient you were working with, what would she tell me about your care?
b) If I were talking to one of your nurse-midwifery colleagues, what would she tell me about your care?
c) Is there anything else that you would like to share about how you provide care in birth?

Thank you very much for your time and thoughts today. If I have any further questions, may I contact you? Thank you again.

Appendix 7: Additional Questions

Additional Questions added during Research Process

Are there situations where you wanted to manage care in a specific way, but you did not?

What people prevented this?

What situations prevented this?

How do you deal with situations where your goal for the patient's labor is not shared by the patient, nurse or doctor?

What motivates you to offer specific options to patients?

With a patient who is in labor: what are your goals as you manage the labor?

Does how well you know your doctor affect the care that you provide?

Does how well you know your nurse affect the care that you provide?

Does how well you know your patient affect the care that you provide?

How do you enlist the support of doctors or nurses and get them to buy in on your plan of management?

What are some things that you do specifically to support vaginal birth?

Tell me about your last delivery:

How do you know when you need to do something?

How do you find out what patients need?

Why is it important for you to be a nurse-midwife?

What was it about nurse-midwifery that made you want to join the profession?

Did these things hold true for your current practice?

If not, why do you still choose to do what you are doing?

Do you help nurses do their job?

What do you do? Why do you do it?

Do you find yourself becoming emotionally attached to your patients?

Does this help or hinder the care you provide?

If you are emotionally bonded to a patient, do you manage that person's care any differently than someone you are not emotionally attached to?

Appendix 8: Factors affecting care of nurse-midwives/ Situational Analysis codes from document.

Goal of this coding: Creation of list of factors that influence, affect care of nurse-midwives.

Code	Total of number of transcripts with code	Number of separate coded segments of text	Code Definition
Society			
Community affecting care	9	24	Statements that reflect the nurse midwife considers the community values and beliefs about labor management during her management of labor.
History affecting care	9	25	Involves situations where previous experiences with procedures or events are influencing the care provided by nurse midwives. This is described as situations "where we used to do this" or "before we did this", reflecting that the care was different in the past than it is currently. Regardless the previous care management options are still being considered as options by the nurse-midwife when she discusses management. Also involves situations where the nurse midwife describes that she was taught to do it this way in school. Includes when the CNM mentions the history of the profession affects care.
Malpractice affecting care	12	21	Situations where nurse midwives or hospitals are considering the potential of a lawsuit related to making choices as to whether to offer or not offer an intervention or procedure during birth.
Insurance affecting care decision	2	2	Situations where patient's insurance states what can and cannot be paid for and these statements are

			considered when making management decisions.
Technology culture affecting care	5	9	Situations where comfort with technology makes it seem less intrusive and easier to use, because everyone is more comfortable with it.
Media affecting care	7	9	Where the nurse midwife states that she thinks birth has been affected by the media portrayals. This affect can be on patient expectations, nurse expectations or CNM, MD expectations.
Inner			
Convenience of CNM affecting plan of care	3	5	Situations where care is affected by the time of day or when care is affected by the nurse-midwife's desire to accomplish other things.
Fatigue affecting plan of care	1	1	When the CNM states that emotional or physical fatigue is affecting the care- i.e. it changes the care she is providing.
Feeling isolated	3	4	Where the CNM feels like she can't count on others to help her provide care for patients and her care has to change as a result of that.
Feeling frustration	5	5	Where the CNM states that her frustration influences the care she provides.
Patient and Family Factors			
Care of other patients affecting care by CNM	2	2	Situations in which a nurse midwife must care for other patients, and this takes CNM away from care of current patient or changes how the CNM would have managed the patient.
Patient's desires affecting care of nurse-midwife	8	24	Situations where the nurse-midwife describes that she considers patient desires when making management decisions.
Patient's family affecting care of nurse-midwife	12	18	Situations where the family members impact the care provided by nurse-midwives- through what they say or do. When the nurse midwife says

			something changed because of their involvement in the process.
Hospital			
Hospital culture affecting care of nurse-midwife	17	77	When the nurse midwife takes into consideration the hospital environment and culture (consists of individuals who work together in the hospital environment and the expected behaviors of these people) when making care management decisions.
Layout of hospital affecting care	2	4	Where the environment of labor and delivery affects the care of the nurse midwives, where the architecture of the unit affects how cnms manage care.
Presence or absence of equipment affecting care	4	4	When the CNM mentions that a hospital has something or does not have something that she wanted to use or did not want to use and has to use, that affects her care choices. This is specifically related to available equipment in the labor and delivery areas.
Hospital procedures affecting care	11	22	Situations in which the hospital procedures are affecting whether a nurse midwife can offer a specific intervention or where procedures specify that things must be done in a certain way. Often this is affected by the potential of malpractice lawsuits related to the specific management procedure.
Hospital financial decisions affecting care	4	6	Includes issues pertaining to hospital staffing, adding equipment, use of old equipment, having specific medications in pharmacy.
Hospital management affecting care	13	16	Where the nurse manager or hospital management affects the care of the CNM via their decision-making or choices or policy creation. This is separate from hospital policy, in that the management is mentioned specifically and policy is created at many different levels.

Hospital staff			
Techs affecting care of CNM	1	1	Where the techs affect what cnms do during the management of labor and birth. Usually focuses around the actual birth process with table set up.
CNM's affecting care of CNM	7	9	When other nurse midwives influence or put pressure on a CNM to manage care in a certain manner.
Physician affecting care of CNM	14	49	Situations where physicians specifically intervene with nurse-midwifery patients (like AROMing CNM patients) without consulting with CNM first or when they require specific procedures. Borderline situations are where consultations are taking place between the CNM and MD and decisions are made together. May also involve situations where the convenience of the physician is affecting the care of the nurse-midwife.
Convenience of MD affecting care of CNM	6	7	Situations where convenience/ desires/ schedule of the MD is affecting care- such as not wanting to sleep in house or needed to do another procedure off the floor or wanting to go home, etc.
Nurses affecting care of CNM	16	108	Situations where the nurse midwife is considering the work of nursing in making decisions about patient management or interventions.
Nursing attitudes affecting care	8	14	Where the CNM specifically states that it is a reaction from the nurse or what she believes or says that causes her to change her care or react differently to care for her patients in labor.
Nursing staffing issues affecting care	7	8	Includes issues related to staffing of labor and delivery and postpartum, includes how filling beds affects staffing. When the nurse midwife is changing her plan of care related to hospital staffing, this is the code.

Nursing interaction	13	33	CNM interacting with pt- code combined with nurses affecting care of cnm
Nurses doing bedside care	10	26	Reflects that nurses are performing the bedside care of the patient, interacting with patient and making decisions related to moment to moment care management.
Respiratory therapy affecting care	6	8	Occurs when CNM mentions respiratory therapy as having effect on her care management
Anesthesia/ CRNAs affecting care	8	12	Occurs when nurse-midwives mention that an anesthesiologist or CRNA affects the care she provides in labor. Does not occur if only epidural or pain relief is mentioned. Provider communication must be part of the quote.
Laboratory affecting care	2	2	Where CNM say that the lab services affect their care in terms of timing or plan.
Using evidence to support patient care	14	62	Situations where the nurse midwife describes that care management or the offering of intervention has changed because of new research based evidence.
Using Clinical list serv and on-line resources	5	5	Mentions on-line sources of information or clinical list serv as sources of information for updating practice.
Using other providers as sources of information	12	18	Includes MDs, cnms- where CNM states she learned management from other providers that changed the care she was providing
Clinical conferences	10	10	Where the CNM mentions that she learned management going to conferences that changed the care she provides
Education programs	5	5	Where the CNM states she learned management from her educational process.
Journal/research evidence	9	10	Where the CNM mentions she reads research articles and these change her practice.

Appendix 9: Values and Beliefs Coding

Goal of this coding: identification of segments of rich text appropriate for further discourse analysis.

Code	Total number of transcripts with code	Number of Separate Coded Segments	Code definition
Inner			
Values quality and safety in birth		20	Where cnms says quality and safety are important goals for labor and birth
Values balancing life	10	15	Where the nurse midwife says she manages care or her schedule so she can have a life outside of her profession.
Values skills	2	3	Where the CNM states she feels it is important for CNM to be skilled in her practice.
Values knowledge	7	8	Where the CNM states she feels knowledge is important to her care
Compassion as CNM quality	9	13	Where the CNM says it is her compassion or love of caring for people that is part of her belief system or structure
Finds Birth fascinating	9	10	CNM states birth is fascinating to her
Values control in birth	7	12	Where the nurse-midwife refers to a desire to be in control over birth, as a motivation for entering profession or for continuing to work
Values responsibility	7	12	Nurse Midwives wanting to get into the profession or enjoying the profession because of the added responsibility and decision making capacity of the role.
Values control, autonomy of nurse-midwife role	7	9	Statements that reflect the nurse-midwife enjoys independently managing patients. a pre-requisite of this may be physician trust in care, as trust must exist in order for autonomy in practice to become reality

Relationships			
Values relationships with patients	19	70	When the nurse-midwife states she values having a positive relationship with the patient. Also involves aspects of continuity of care- where the CNM values the relationship with the patient in the moment and also over time.
Values totality of the person	4	6	Where the nurse midwife states that she values understanding the woman in whole of her experience, in her environment, in the whole of her lifespan
Values emotional reactions	17	26	The Nurse midwife states she enjoys when the patient or family members respond emotionally to birth or other events.
Values happiness in birth	16	33	CNM states she values patient happiness in birth
Values choice in labor	11	28	Statements that reflect desire that women are actively involved in making decisions during their labor. Also those patients are able to make their personal beliefs known and that these are taken into consideration when decisions about intervention or management of labor are being made by the nurse midwife.
Values empowering women	17	44	When the CNM says she wants to empower women. Values making a positive improvement in a woman's life. Where she is getting better- where CNM is making a difference.
Values spending time with patients	14	19	Where the nurse midwife specifically states that she likes to spend time with patients, talking and providing information, education, and learning about their family.
Values working as part of a health care team	13	30	Situations where nurse midwife states a desire to work within a team to provide rapid intervention if needed or provide greater options to patients.
Values relationship with MD	9	17	When the CNM mentions that she likes working with MD, or that the MDs are supportive of her practice

Values relationship with nurse	3	3	Where the CNM mentions that she wants the nurse to have a good relationship with her patient or with herself.
Process Focused			
Values normal processes of birth	10	28	When CNM mentions that normalcy is important. Definition of normalcy is often assumed and needs to be evaluated more. Normal is described as least intervention as possible in labor, inventions described as medical invasive procedures and not physical actions.
Values individual, approp use of intervention	3	3	Where CNM says that individualized and/or appropriate use of technology or intervention is important in the management of labor and or birth. Areas co-coded with using intervention to bump progress toward vaginal delivery- segments of text appropriate to this code also under that code.
Values alternative medicine	3	5	Where the CNM mentions that she finds alternative health care approaches important or valuable to her or her care.
Values completion of birth process	11	17	Where the nurse-midwife mentions that her satisfying moments arrive at or after the completion of the birth process or at the completion of an interaction with a patient. This is in comparison to a nurse-midwife who values the relationship over time or the process of care.
Values vaginal delivery	5	6	Values the goal of achieving a vaginal birth over other birth outcomes, additional segments appropriate for this code also under process code: achieving vaginal delivery
Values medical model	8	15	Enjoys working in the hospital system and enjoys intervening in birth, whether thru medical or action. States does not like to stand around and just watch labor. Examples: statement that reflects desires "safety in labor" obtained through labs, controlling birth, external fetal monitoring.

Values problem solving	4	8	Nurse midwife enjoys the problem solving aspects of the role. Examples: enjoys figuring out what is happening with the patient physically, emotionally, during her labor with the goal of selecting an intervention that will result in the birth of a healthy baby and healthy mother.

Appendix 10: Constructionist Grounded Theory Coding

Goal of this coding: rich theoretical description of process of nurse-midwifery practice. These codes were further elevated and organized into theory of Shaping Birth. This process of elevation is described in the findings section.

Codes	Total number of transcripts with code	Number of Coded Segments	Code Definition
Creating relationship with patient through communication	10	63	2.6.10: changed code from creating relationship with patient through spending time to through communication. In the interviews- it's that the CNM is at the patient's bedside talking to them, asking them questions and this is what I meant by spending time. "Through communication" is more specific to the action that the CNM is really doing. 2.17.12: the goal of this code is to create trust between the CNM and the patient... thus the CNM is creating a relationship communication in order to create trust....not sure yet if the title of this code should be changed.
Involving CNM emotionally in care	16	44	where the CNM involves herself emotionally in the care as a way to encourage her own action or someone else's action during the birth process
Encouraging patients to make management decisions	19	44	Situations where nurse midwives use various techniques, including education, to encourage patients to participate and/or actively influence the management of their own labor.
Encouraging patients	10	24	This is where the nurse midwife encourages a patient in some manner, either verbally or physically, to continue laboring or trying for a vaginal delivery.

Shaping expectations through education	18	40	Situations where the nurse midwife uses education as an intervention with patients to stimulate a change in labor progress or management. Also involves altering patient's expectations of labor via education.
Protecting patients from being railroaded	19	20	Situations where the nurse midwife alters her communication with nurses or doctors in order to protect her patient from being treated in a manner that may result in a cesarean birth. 4/2/12 What are we protecting patient from and what is the CNM doing when she is protecting? CNM is changing the hospital environment of birth in some manner- she is either affecting the relationship with the other people involved in the birth process, so that they interact differently, maybe more individually or more supportive of the CNM desires, or she is physically changing the environment on her time frame through backfilling the nurses jobs. What is she protecting patients from? From being patient A in labor room 2--- she is giving patient a name and an identity within the birth process, she is creating a situation where the patient is not placed on the L&D conveyor belt.
Managing care while not at bedside	5	13	Where the nurse midwife manages care while not at bedside- such as when nurses come to CNM and ask for intervention and CNM authorizes intervention without personally evaluating patient. Also involves where the nurse midwife is working behind the

			scenes at the nurses' station or with her MD/CNM partners to negotiate or provide care to her patients.
Buffering the nurse	13	13	Where the CNM is doing some of the work of the nurse or educating the nurse or helping the nurse out in some way to affect the care of her patients.
Creating relationship with nurse	8	15	Where the CNM states she specifically creates a relationship with a nurse to improve the care to her patients.
Reducing the pressure of nurses	8	11	Things that nurse-midwives do to make the job of bedside hospital nurses easier. Often done with the goal of making the job of the nurse-midwife easier.
Developing trust with MD	17	31	Involves creating relationships with MD so that they are able to respond quickly and in the manner the nurse-midwife desires when they ask for assistance.
Using intervention to bump progress toward vaginal delivery	19	45	Situations where nurse-midwives specifically intervene with intervention (physical, medical, invasive or non-invasive) to support a vaginal birth.
Making labor a good experience	14	30	Where the CNM states the goal is a good labor experience for the mother but also involves making sure the labor is how the mother desires, allowing her to have options.
Making labor progress	15	42	Desire to make labor progress as factor in making decisions about management of birth. Unsure how this is in relationship to medical management desires or use of evidence or care based upon history. 4/2/12 Some component of this involves giving the patient space to labor. See interview Olivia-

			section 39-42
Achieving vaginal delivery	15	28	Where the nurse midwife describes success is the (healthy) vaginal birth of the baby. This also occurs when the nurse-midwife describes it as a failure or having disappointment in having to do a cesarean.

References

Agency for Healthcare Research and Quality, & U.S. Department of Health and Human Services. (2008). National Healthcare Quality Report 2008. Rockville, MD.

Albers, L. L., Schiff, M., Gorwoda, J.G. (1996). The Length of Active Labor in Normal Pregnancies. *Obstetrics & Gynecology, 87*(3), 355-359.

Alfirevic, Z., Kelly, A., & Dowswell, T. (2009). Intravenous Oxytocin Alone for Cervical Ripening and Induction of Labor. *Cochran Database of Systematic Reviews 2009*(Issue 4. Art. No.: CD003246. DOI: 10.1002/14651858.CD003246.pub2.).

Allen, D. (2004). Ethnomethodological Insights into the Insider-Outsider Relationships in Nursing Ethnographies of Healthcare Settings. *Nursing Inquiry, 11*(1), 14-24.

Ament, L. A. (2007). *Professional Issues in Midwifery*. Sudbury, Massachusetts: Jones and Bartlett Publishers.

American College of Nurse-Midwives. (2008). Nurse-Midwifery in 2008: Evidence-Based Practice. Silver Spring, MD.

American College of Nurse-Midwives. (2012). Fact Sheet: Essential Facts about Midwives. Silver Spring, MD.

Amnesty International. (2010). Deadly Delivery: The Maternal Health Care Crisis in the USA. London.

Andrews, R. M. (2008). *The National Hospital Bill: The Most Expensive Conditions by Payer, 2006*. Rockville, MD: Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb59.pdf.

Anim-Somuah, M., Smyth, R., & Howell, C. (2005). Epidural versus non-epidural or no analgesia in labour. *Cochrane Database of Systematic Reviews 2005*(Issue 4. Art. No.: CD000331. DOI: 0.1002/14651858.CD000331.pub2.).

Antonovsky, A. (1979). *Health, Stress, and Coping*. San Francisco: Jossey-Bass.

Antonovsky, A. (1993). The implications of salutogenesis: an outsider's view. In A. Turnbull, J. M. Patterson & S. G. Behr (Eds.), *Cognitive Coping: Families and Disability*. Baltimore, MD: Brookes.

Artinian, B. M., Giske, T., & Cone, P. H. (2009). *Glaserian Grounded Theory in Nursing Research: Trusting Emergence*. New York: Springer.

Association for Health Care Research and Quality. (2008). AHRQ Mission. 2008, from http://www.ahrq.gov/about/budgtix.htm

Banks, A. C. (1999). *Birth Chairs, Midwives and Medicine*. Jackson, MI: University Press of Mississippi.

Benner, P. (2001). *From Novice to Expert: Excellence and Power in Clinical Practice*. Upper Saddle River: Prentice Hall.

Berwick, D. M. (2002). A User's Manual for the IOM's 'Quality Chasm' Report. *Health Affairs*(May/June), 80-90.

Block, J. (2007). *Pushed: The Painful Truth about Childbirth and Modern Maternity Care*. Cambridge: Da Capo

Bogdan-Lovis, E. A. (1997). Misreading the Power Structure: Liberal Feminists' Inability to Influence Childbirth. *Michigan Feminist Studies, 11*, 59-79.

Boorse, C. (1975). On the Distinction between Disease and Illness. *Philosophy and Public Affairs, 5*(1), 49-68.

Boorse, C. (1977). Health as a Theoretical Concept. *Philosophy of Science, 44*, 542-573.

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Bourdieu, P. (1990). *The Logic of Practice* (R. Nice, Trans.). Stanford: Stanford University Press.

Bourdieu, P. (1991). *Language and Symbolic Power* (R. Nice, Trans.). Cambridge: Polity Press.

Breckinridge, M. (1981). *Wide Neighborhoods: A Story of the Frontier Nursing Service*. Lexington: University Press of Kentucky.

Callaghan, W. M., Creanga, A. A., & Kuklina, E. V. (2012). Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States. *Obstetrics and Gynecology, 120*(5), 1029-1036.

Carvalho, B., Wang, P., Cohen, S. E. . (2006). A survey of labor patient-controlled epidural anesthesia practice in California hospitals. *International Journal of Obstetric Anesthesia, 15*(3), 217-222.

Cassidy, T. (2006). *Birth: The Surprizing History of How We are Born*. New York: Atlantic Monthly Press.

Chaillet, N., & Dumont, A. (2007). Evidence-Based Strategies for Reducing Cesarean Section Rates: A Meta-Analysis. *Birth, 34*(1), 53-64.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practice Guide Through Qualitative Analysis*. London: Sage.

Charmaz, K. (2009a, June 24-25, 2009). [Introduction to Grounded Theory: A Social Constructionist Approach].

Charmaz, K. (2009b). [Personal communication].

Charmaz, K. (2009c). Shifting the Grounds: Constructivist Grounded Theory Methods. In J. Morse (Ed.), *Developing Grounded Theory: The Second Generation* (pp. 127-193). Walnut Creek: Left Coast Press.

Chassin, M. R., & Galvin, R. W. (1998). The urgent need to improve health care quality. Institute of Medicine National Roundtable on Health Care Quality. *Journal of the American Medical Association, 280*(11), 1000-1005.

Clarke, A. E. (2005). *Situational Analysis: Grounded Theory After the Postmodern Turn*. Thousand Oaks: Sage.

Closs, S. J., & Cheater, F. M. (1999). Evidence for Nursing Practice: A Clarification of the Issues. *Journal of Advanced Nursing, 30*(1), 10-17.

Coalition for Improving Maternity Services. (1996). The Mother-Friendly Childbirth Initiative. Retrieved October 10, 2008, from http://www.motherfriendly.org/pdf/MFCI_english.pdf

Cragin, L. (2004). The Theoretical Basis for Nurse-Midwifery Practice in the United States: A Critical Analysis of Three Theories. *Journal of Midwifery and Women's Health, 49*(5), 381-389.

Cragin, L., & Kennedy, H. P. (2006). Linking obstetric and midwifery practice with optimal outcomes. *J Obstet Gynecol Neonatal Nurs., 35*(6), 779-785.

Cunningham, F., Bangdiwala, S., Brown, S., Dean, T., Frederiksen, M., Rowland-Hogue, C., . . . Zimmet, S. (2010). *National Institutes of Health Consensus Developent Conference Statement: Vaginal Birth after Cesarean: New Insights, March 8-10, 2010*. Obstetrics and Gynecology.

Cunningham, F. G., MacDonald, P.C., Leveno, K.J., Gant, N.F., Gilstrap, L.C. (1993). *Williams Obstetrics* (19th ed.). Norwalk, CT: Appleton & Lange.

Danel, I., Berg, C., Johnson, C. H., & Atrash, H. (2003). Magnitude of maternal morbidity during labor and delivery: United States, 1993-1997. *Am J Public Health, 93*(4), 631-634.

Davis-Floyd, R., Barclay, L., Daviss, B. A., & Tritten, J. (2009). *Birth Models that Work*. Berkeley: University of California Press.

Davis-Floyd, R., & Sargent, C. (Eds.). (1997). *Childbirth and Authoritative Knowledge*. Berkeley: University of California Press.

Davis, L. G., Riedmann, G. L., Sapiro, M., Minogue, J. P., & Kazer, R. R. (1994). Cesarean section rates in low-risk private patients managed by certified nurse-midwives and obstetricians. *Journal of Nurse Midwifery, 39*(2), 91-97.

Declercq, E. (1994). The trials of Hanna Porn: the campaign to abolish midwifery in Massachusetts. *Am J Public Health, 84*(6), 1022-1028.

Declercq, E., Sakala, C., Corry, M., & Applebaum, S. (2006). Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences. New York: Childbirth Connection.

Declercq, E., Sakala, C., Corry, M., & Applebaum, S. (2007). Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences: Conducted January-February 2006 for Childbirth Connection by Harris Interactive(R) in partnership with Lamaze International. *J Perinat Educ, 16*(4), 15-17. doi: 10.1624/105812407x244778

Devitt, N. (1979a). The statistical case for elimination of the midwife: fact versus prejudice, 1890-1935 (Part I). *Women Health, 4*(1), 81-96.

Devitt, N. (1979b). The statistical case for elimination of the midwife: fact versus prejudice, 1890--1935 (Part 2). *Women Health, 4*(2), 169-186. doi: 10.1300/J013v04n02_06

Downe, S., Simpson, L., & Trafford, K. (2007). Expert intrapartum maternity care: a meta-synthesis. *Journal of Advanced Nursing, 57*(2), 127-140.

Downie, R., & Macnaughten, J. (2000). *Clinical Judgement: Evidence in Practice*. Oxford: Oxford University Press.

Duranti, A. (2001). Linguistic Anthropology: History, Ideas, and Issues. In A. Duranti (Ed.), *Linguistic Anthropology: A Reader* (pp. 1-38). Hoboken: Wiley-Blackwell.

Ehrenreich, B., & English, D. (1970). *Witches, Midwives, & Nurses: A History of Women Healers*. New York: The Feminist Press.

Fairclough, N. (2003). *Analysing Discourse: Textual Analysis for Social Research*. New York: Routledge.

Foster, J., Anderson, A., Houston, J., & Doe-Simkins, M. (2004). A Report of a Midwifery Model for Training Traditional Midwives in Guatemala. *Midwifery, 20*, 217-225.

Foster, J., & Health, A. (2007). Midwifery and the Development of Nursing Capacity in the Dominican Republic: Caring, Clinical Competence, and Case Management. *Journal of Midwifery and Women's Health, 52*(5), 499-504.

Foucault, M. (1972). *The Archaeology of Knowledge and the Discourse on Language*. New York: Pantheon Books.

Foucault, M. (1978). The Incitement to Discourse *The History of Sexuality* (Vol. I). New York: Vintage Books.

Gibboney, D. G. (Ed.). (1978). *Remedies, Recipes, Spells and Potions of the 1800's*. Georgia: Self-Published.

Goffman, E. (1959). *The Presentation of Self in Everyday Life*. New York: Anchor Books.

Goffman, E. (1967). *Interaction Ritual*. New York: Pantheon Books.

Green, J. A. (2007). *Prescribing by the Numbers*. Baltimore: John Hopkins.

Gubrium, J. F., & Holstein, J. A. (2008). The Constructionist Mosaic. In J. A. Holstein & J. F. Gubruim (Eds.), *Handbook of Constructionist Research* (pp. 3-10). New York: The Guilford Press.

Hagland, M. (2009). *Transformative Quality: The Emerging Revolution in Health Care Performance*. New York: Productivity Press.

Halldorsdottir, S., & Karlsdottir, S. I. (1996). Journeying through labour and delivery: Perceptions of women who have given birth. *Midwifery*, 48-61.

Harding, S. (Ed.). (2004). *The Feminist Standpoint Theory Reader*. New York: Routledge

Hartsock, N. C. M. (1998). *The Feminist Standpoint Revisted & Other Essays*. Boulder: Westview Press.

Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochran Database of Systematic Reviews 2008*(4), Art. No.: CD004667. DOI:004610.001002/14651858.CD14004667.pub14651852.

Hennink, M. (2009a, November 6, 13, 2009). [In-Depth Interviewing].

Hennink, M. (2009b). [Personal communication].

Herman, E., & Chomsky, N. (1988). *Manufacturing Consent: The Political Economy of the Mass Media*. New York: Pantheon.

Howarth, G., & Botha, D. (2001). Amniotomy plus Intravenous Oxytocin for Induction of Labor. *Cochran Database of Systematic Reviews 2001*(Issue 3. Art.: CD003250. DOI: 10.1002/14651858.CD003250).

Institute of Medicine. (1999). *To Err is Human: Building a Safer Health System*. National Academy Press.

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*: National Academy of Sciences.

Institute of Medicine. (2003). *Priority Areas for National Action: Transforming Health Care Quality*. Washington, DC: National Academies Press.

Definition of the Midwife (2005).

Jacobs, S., American College of Nurse-Midwives. (1993). *Having Your Baby with a Nurse-Midwife: Everything You Need to Know to Make an Informed Decision*. New York: Hyperion.

James, E. L. (2011). *Fifty Shades Freed*. New York: Random House.

Janssen, P. A., Ryan, E.M., Etches, D.J., Klein, M.C., Reime, B. (2007). Outcomes of Planned Hospital Birth Attended by Midwives Compared with Physicians in British Columbia. *Birth, 34*(2), 140-147.

Jones, J., & Saad, L. (2012). Gallup Poll: Honesty and Ethics of Professions. USA Today: Gallup.

Jones, S. J. (2000). *Ethics in Midwifery* (2nd ed.). Edinburgh: Mosby.

Jordan, B., & Davis-Floyd, R. (1992). *Birth in Four Cultures*. Long Grove, Illinois: Waveland Press.

KaiserNetwork.org (Producer). (2007, 10/24/2007). Average Medical Costs for Prenatal Care, Childbirth in U.S. About $7,600, Government Report Says. Retrieved from http://www.kaisernework.org/daily_reports/

Kennedy, H. P. (1999). *Linking Midwifery Practice to Outcomes: A Delphi Study.* (Doctor of Philosophy Dissertation), University of Rhode Island. UMI database.

Kennedy, H. P. (2006a). A Concept Analysis of Optimality. *JOGNN, 35*, 763-769.

Kennedy, H. P. (2006b). A concept analysis of optimality in perinatal health. *J Obstet Gynecol Neonatal Nurs., 35*(6), 763-769.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press.

Lamb, G. (2009). [Personal Communication].

Landivar, L. C. (2013). Men in Nursing Occupations *American Community Survey*: U.S. Census Bureau.

Lange, G., & Kennedy, H.P. (2006). Student Perceptions of Ideal and Actual Midwifery Practice. *Journal of Midwifery and Women's Health, 51*(2), 71-77.

Larkin, P., Begley, C., & Devane, D. (2007). Women's Experiences of Labor and Birth: An Evolutionary Concept Analysis. *Midwifery, 7*(10), 1-11.

Latimer, J. (2008). Critical Constructionism in Nursing Research. In J. A. Holstein & J. F. Gubruim (Eds.), *Handbook of Constructionist Research* (pp. 153-169). New York: Guilford Press.

Lavender, T., Walkinshaw, S., & Walton, I. (1999). A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery, 15*, 40-46.

Lehrman, E. J. (1981). Nurse-Midwifery Practice: A Descriptive Study of Prenatal Care. *Journal of Nurse-Midwifery, 26*(3), 27-41.

Lehrman, E. J. (1988). *A Theoretical Framework for Nurse-Midwifery Practice.* (Doctoral Dissertation), University of Arizona.

Letsky, M., & Warner, N. W. (2008). Macrocognition in Teams. In M. P. Letsky, N. W. Warner, S. M. Fiore & C. A. P. Smith (Eds.), *Macrocognition in Teams* (pp. 1-11). Burlington, VT: Ashgate Publishing Company.

Levit, K., Wier, L., Stranges, E., Ryan, K., & Elixhauser, A. (2009). *HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2007*. Rockville, MD: Retrieved from http://www.hcup-us.ahrq.gov/reports/factsandfigures/2007/TOC_2007.jsp.

Low, L. K., Dawley, K., Jessup, D., Burkhardt, P., McGill, M., Kennedy, H.P., Williams, D., Mielcarski, E., & Martin, K. (2005). Philosophy of the American College of Nurse-Midwives. In ACNM (Ed.).

Lowe, N. (1996). The Pain and Discomfort of Labor and Birth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 25*(1), 82-92.

MacDorman, M., & Mathews, T. (2008). Recent Trends in Infant Mortality in the United States. In U.S. Department of Health and Human Services (Ed.): Centers for Disease Control,.

MacDorman, M., & Singh, G. (1998). Midwifery Care, Social and Medical Risk Factors and Birth Outcomes in the USA. *Journal of Epidemiology and Community Health, 52*, 310-317.

Mahoney, S., & Malcoe, L. (2005). Cesarean delivery in Native American women: are low rates explained by practices common to the Indian health service? *Birth, 23*(3), 170-178.

Maietta, R. (2009a). [2009 Qualitative Summer Institute].

Maietta, R. (2009b). [Core Principles in Qualitative Research].

Mander, R. (1997). Choosing the choices in the USA: examples in the maternity area. *Journal of Advanced Nursing, 25*(6), 1192-1197.

Martin, E. (1987). *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.

Martin, J., Hamilton, B., Sutton, P., Ventura, S., Menacker, F., Kirmeyer, S., & Munson, M. (2007). Births: Final Data for 2005. *National Vital Statistics Reports,, 56*(6), 1-104.

Martin, J., Hamilton, B. E., Ventura, S. J., Osterman, M., Wilson, E., & Mathews, T. J. (2012). Births: Final Data for 2010. *National Vital Statistics Reports, 61*(1).

Maternity Center Association. (April, 2004). What Every Pregnant Woman Needs to Know about Cesarean Section. New York: MCA.

McCool, W. F., & McCool, S. J. (1989). Feminism and nurse-midwifery. Historical overview and current issues. *J Nurse Midwifery, 34*(6), 323-334.

McCool, W. F., & Simeone, S. A. (2002). Birth in the United States: an overview of trends past and present. *Nursing Clinics North America, 37*(4), 735-746.

Miles, M. B., & Huberman, A. M. (1994). Making Good Sense: Drawing and Verifying Conclusions *Qualitative Data Analysis* (Second ed., pp. 245-287). Thousand Oaks: Sage.

Mitford, J. (1992). *The American Way of Birth*. New York: Penguin Group.

Morse, J. (2001). Situating Grounded Theory Within Qualitative Inquiry. In R. S. Schreiber & P. N. Stern (Eds.), *Using Grounded Theory in Nursing* (pp. 1-15). New York: Springer Publishing.

Murphy, D. (2008, January 18, 2009). Concepts of Disease and Health. *The Sanford Encyclopedia of Philosophy.* 2009, from http://plato.stanford.edu/entries/health-disease/

Murphy, P., & Fullerton, J. (1998). Outcomes of Intended Home Births in Nurse-Midwifery Practice: A Prospective Descriptive Study. *Obstetrics and Gynecology, 1998*(92), 461-470.

Murphy, P., & Fullerton, J. (2001). Measuring Outcomes of Midwifery Care: Development of an Instrument to Assess Optimality. *Journal of Midwifery and Women's Health, 46*(5), 274-284.

National Institute of Health. (2006). National Institutes of Health state-of-the-science conference statement: Cesarean delivery on maternal request March 27-29, 2006. *Obstetrics and Gynecology, 107*(6), 1386-1397.

National Institutes of Health. (2006). Cesarean Delivery on Maternal Request. In N. O. o. t. Director (Ed.), *NIH State-of-the-Science Conference Statement*. Washington, DC.

National Priorities Partnership. (2008). National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. In National Quality Forum (Ed.). Washington, DC: National Quality Forum.

National Quality Forum. (June, 2009). *Waste Not, Want Not: The Right Care for Every Patient*. Washington, DC.

Nelson, E. C., Batalden, P. B., Godfrey, M. M., Headrick, L. A., Huber, T. P., Mohr, J. J., & Wasson, J. H. (2001). Microsystems in Health Care: The Essential Building Blocks of High Performing Systems: Robert Wood Johnson Foundation.

Nemcok, J. C. (1980). An Analysis of 353 Vaginal Deliveries: Natural Versus Anesthesia. *Journal of the American Osteopathic Association, 80*(4), 247-253.

Nickel, S., Gesse, T., MacLaren, A. (1992). Ernestine Wiedenbach: Her Professional Legacy. *Journal of Nurse-Midwifery, 37*(3), 161-167.

Nicoloff, N. (2012). Creating a Culture of First Impressions and a Continuum of Patient Care. *Becker's Hospital Review*.

NIH. (2006). *Cesarean Delivery on Maternal Request*. Paper presented at the NIH State of the Science Conference, Washington, DC. http://consensus.nih.gov/2006/2006CesareanSOS027main.htm

Nikander, P. (2008). Constructionism and Discourse Analysis. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 413-428). New York: The Guilford Press.

Nordenfelt, L. (2001). *Health, Science, and Ordinary Language* (Vol. 110). New York: Rodopi.

Northouse, P. G. (2013). *Leadership: Theory and Practice* (Sixth ed.). Los Angeles: Sage Publications.

Nystedt, A., Edvardsson, D., & Willman, A. (2004). Epidural analgesia for pain relief in labour and childbirth - a review with a systematic approach. *Journal of Clinical Nursing, 13*(4), 455-466.

Oakley, D., Murland, T., Mayes, F., Hayashi, R., Petersen, B., Rorie, C., & Anderson, F. (1995). Processes of Care: Comparisons of Certified Nurse-Midwives and Obstetricians. *Journal of Nurse-Midwifery, 40*(5), 399-405.

Oakley, D., Murray, M. E., Murtland, T., Hayashi, R., Andersen, H. F., Mayes, F., & Rooks, J. (1996). Comparisons of outcomes of maternity care by obstetricians and certified nurse-midwives. *Obstetrics & Gynecology, 88*(5), 823-829.

Organization for Economic Co-operation and Development, & Institute for Research and Information in Health Economics. (2008). Total Health Expendatures per capita, by country, in US $.

The Overuse, Underuse, and Misuse of Health Care, United States Senate 1-12 (2008).

Ortner, S. B. (1974). Is Female to Male as Nature is to Culture. In M. Z. Rosaldo & L. Lamphere (Eds.), *Women, Culture, & Society* (pp. 67-87). Stanford: Stanford University Press.

Ortner, S. B. (2006). *Anthropology and Social Theory: Culture, Power, and the Acting Subject*. Durham: Duke University Press.

Pettersson, K., & Stone, K. (2005). *Profiling Midwifery Services in the Americas*. Washington, DC: Pan American Health Organization.

Poole, J. H. (2003). Analgesia and anesthesia during labor and birth: implications for mother and fetus. *Journal of Obstetrics, Gynecology, and Neonatal Nursing, 32*(6), 780-793.

Ransom, E. R., Joshi, M. S., Nash, D. B., & Ransom, S. B. (Eds.). (2008). *The Health Care Quality Book: Vision, Strategy, and Tools* (Second ed.). Chicago: Health Administration Press.

Ritchie, J., & Lewis, J. (Eds.). (2006). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications.

Rooks, J. P. (1997). *Midwifery and Childbirth in America*. Philadelphia: Temple University Press.

Rosenblatt, R. A., Dobie, S., Hart, L.G. (1997). Interspecialty Differences in the Obstetric Care of Low-Risk Women. *American Journal of Public Health, 87*, 344-351.

Sacket, D. L., Rosenberg, W. M., Muir Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence-based Medicine: What it is and What it isn't. *British Medical Journal, 312*, 71-72.

Sakala, C. (1988). Content of Care by Independent Midwives: Assistance with Pain in Labor and Birth. *Social Science and Medicine, 26*(11), 1141-1158.

Sakala, C., Corry, M. P., Childbirth Connection, Reforming States Group, & Milbank Memorial Fund. (2008). Evidence-Based Maternity Care: What It Is and What It Can Achieve (pp. 1-128). New York.

Sallaz, J. J., & Zavisca, J. (2007). Bourdieu in American Sociology. *Annual Review of Sociology, 33*, 21-41.

Save the Children. (2008). 2008 Mother's Index Rankings *State of the World's Mothers' Report*. Westport.

Schreiber, R. S., & Stern, P. N. (Eds.). (2001). *Using Grounded Theory in Nursing*. New York: Springer Publishing Company.

Schuiling, K. D., Sipe, T. A., & Fullerton, J. (2005). Findings from the Analysis of the American College of Nurse-Midwives' Membership Surveys: 2000-2003. *Journal of Midwifery and Women's Health, 50*(1), 8-15.

Schuiling, K. D., Sipe, T. A., & Fullerton, J. (2010). Findings from the Analysis of the American College of Nurse-Midwives' Membership Surveys: 2006-2008. *Journal of Midwifery and Womens Health, 55*(4), 299-307.

Scott, J. (1985). *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.

Shortell, S. M., Bennett, C. L., & Byck, G. R. (1998). Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. *Milbank Quarterly, 76*(4), 593-624.

Simkin, P. (1996). The Experience of Maternity in a Woman's Life Cycle. *JOGNN, 25*(3), 247-252.

Simonds, W., Rothman, B. K., & Norman, B. M. (2007). *Laboring On: Birth in Transition in the United States*. New York: Routledge.

Simpson, K. R., & Poole, J. H. Labor induction & augmentation. Knowing when, and how, to assist women in labor. *AWHONN Lifelines. 1998 Dec;2(6):39-42.*

Starr, P. (1982). *The Social Transformation of American Medicine*. New York: Harper Collins.

Taylor, C. (2002). *Giving Birth: A Journey into the World of Mothers and Midwives*. New York: Penguin Putnam.

The Partnership for Maternal Newborn and Child Health. (2005). Conceptual and Institutional Framework. In W. H. Organization (Ed.), (pp. 1-28): World Health Organization.

Thompson, J. E., Oakley, D., Burke, M., Jay, S., & Conklin, M. (1989). Theory Building in Nurse-Midwifery. *Journal of Nurse-Midwifery, 34*(3), 120-130.

Thoms, H. (1960). *Our Obstetric Heritage: The Story of Safe Childbirth*. Hamden, CT: The Shoe String Press.

Tomey, A. M. (2002). Ernestine Wiedenbach: The Helping Art of Clinical Nursing. In A. M. A. Tomey, M.R. (Ed.), *Nursing Theorists and Their Work* (Fifth ed., pp. 84-97). St. Louis: Mosby.

Torvaldsen, S., Roberts, C., Bell, J., & Raynes-Greenow, C. (2009). Discontinuation of Epidural Analgesia Late in Labour for Reducing the Adverse Delivery Outcomes Associated with Epidural Analgesia. *Cochran Database of Systematic Reviews 2004*(Issue 4. Art. No.: CD004457. DOI: 10.1002/14651858.CD004457.pub2.).

Tracy, S., & Tracy, M. (2003). Costing the Cascade: Estimating the Cost of Increased Obstetric Intervention in Childbirth using Population Data. *BJOG, 110*, 717-724.

Tracy, S. K., Sullivan, E., Wang, Y. A., Black, D., & Tracy, M. (2007). Birth outcomes associated with interventions in labour amongst low risk women: a population-based study. *Women Birth, 20*(2), 41-48.

U.S. Department of Health and Human Services. Healthy People 2010: Understanding and Improving Health. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. Washington, D.C.: U.S. Government Printing Office Retrieved from http://www.healthypeople.gov/.

US Congress Department of Technology Assessment. (1986). *Nurse-Practitioners, Physician Assistants and Certified Nurse-Midwives: A Policy Analysis*. US Government Printing Office.

Varney, H. (1980). The Profession of Nurse-Midwifery *Nurse-Midwifery* (2nd ed., pp. 3-17). Boston: Blackwell.

Varney, H. (1987). *Nurse-Midwifery*. St. Louis: Blackwell Mosby.

Varney, H., Kriebs, J. M., & Gegor, C. (2004). *Varney's Midwifery* (4th ed.). Sudbury, MA: Jones and Bartlett Publishers.

Viswanathan, M., Visco, A., Hartmann, K., Wetchter, M., Gartlehner, G., Wu, J., . . . Lohr, K. (March, 2006). *Cesarean Delivery on Maternal Request. Evidence Report/ Technology Assessment No. 133*. Rockville, MD: Retrieved from http://www.ahrq.gov/downloads/pub/evidence/pdf/cesarean/cesarreq.pdf.

Wagner, M. (1994). *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*. Camperdown, NSW: ACE Graphics.

Wagner, M. (2000). Technology in Birth: First Do No Harm. *Midwifery Today*.

Waltz, C. F., Strickland, O. L., & Lenz, E. R. (2005). *Measurement in Nursing and Health Research* (3rd ed.). New York: Springer Publishing Company.

World Health Organization. (1948). WHO definition of Health. Retrieved January 12, 2009, from http://www.who.int/about/definition/en/print.html

World Health Organization. (1997). Care in Normal Birth: A Practical Guide. In Maternal and Newborn Health, Safe Motherhood & Division of Reproductive Health (Eds.), *Technical Working Group*. Geneva.

World Health Organization Department of Making Pregnancy Safer. (2007). Annual Report 2007 (pp. 1-68). Geneva: World Health Organization.

Young, D. (2007). New Evidence on Cesareans. *Birth, 34*(1), 1-2.