1995

Career patterns of nurse-midwives in a specific geographical area

Samara Isobel Kemp
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

---

Recommended Citation

Kemp, Samara Isobel, "Career patterns of nurse-midwives in a specific geographical area" (1995).
Master's Theses. 1151.
DOI: <https://doi.org/10.31979/etd.tkvx-vb3v>
https://scholarworks.sjsu.edu/etd_theses/1151

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

**A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600**

CAREER PATTERNS OF NURSE-MIDWIVES IN A
SPECIFIC GEOGRAPHICAL AREA

A Thesis

Presented to

The Faculty of the School of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

by

Samara Isobel Kemp

December, 1995

UMI Number: 1377242

**Copyright 1995 by
Kemp, Samara Isobel
All rights reserved.**

**UMI Microform 1377242
Copyright 1996, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
**300 North Zeeb Road
Ann Arbor, MI 48103**

© 1995

Samara Isobel Kemp

ALL RIGHTS RESERVED

APPROVED FOR THE SCHOOL OF NURSING

Coleen Saylor, Ph.D., R.N.

Rosemary J. Mann, C.N.M., J.D.

Linda V. Walsh, C.N.M., Ph.D.

APPROVED FOR THE UNIVERSITY

ABSTRACT

CAREER PATTERNS OF NURSE-MIDWIVES IN A SPECIFIC GEOGRAPHICAL AREA

by Samara I. Kemp

This nonexperimental, naturalistic study was conducted to determine the role and functions, practice arrangements, and professional relationships of five female nurse-midwives practicing in the San Joaquin Valley of northern California. The purpose was to provide guidance and leadership for inexperienced nurse-midwives in the beginning stages of their careers.

The data were collected through use of an interview guide and were analyzed with content analysis based on categories from the literature. Results suggest that the subjects prefer continuity of care for their clients, practice arrangements with more independence, such as in a birth-center setting, and better compensation for the hours they spend as a nurse-midwife.

The study concluded with recommendations that new nurse-midwives (a) perform demographics regarding the need for CNMs in the specific geographical area of interest, (b) appreciate their own skills and profession, and (c) be legally astute with thorough and concise documentation.

ACKNOWLEDGMENTS

The author is indebted to many people for their assistance and cooperation in the completion of this study.

To Dr. Coleen Saylor who gave thoughtful and constructive assistance throughout the entire process and development of this thesis.

To my children, Bradford, Brett, Darren, and Shawni, for all their love and support during my endeavor to obtain a Masters Degree in Nursing.

A very special thanks to all my friends who were supportive and encouraging as I began a new career in nurse-midwifery.

TABLE OF CONTENTS

Chapter	Page
1. INTRODUCTION.....	1
Background.....	1
Problem Statement.....	5
Purpose.....	6
Research Questions.....	6
Summary.....	7
2. CONCEPTUAL FRAMEWORK AND	
REVIEW OF LITERATURE.....	8
Conceptual Framework.....	8
Literature Review.....	10
Role and Functions.....	10
Practice Arrangements.....	12
Professional Relationships.....	14
Trends in Nurse-Midwifery Careers.....	16
3. METHODOLOGY.....	19
Research Design.....	19
Sample and Setting.....	20
Instrument.....	20
Data Collection.....	21
Data Analysis.....	21
4. FINDINGS AND INTERPRETATION.....	23
Demographic Description of Subjects.....	23
Role and Functions.....	24
Practice Arrangements.....	26

Chapter	Page
Professional Relationships.....	28
5. DISCUSSION.....	32
Summary of Study.....	32
Conclusions.....	34
Scope and Limitations.....	36
Recommendations.....	36
REFERENCES.....	38
APPENDIXES	
A. Human Subjects Review Board Approval.....	42
B. Agreement to Participate.....	44
C. Interview Guide.....	47

Chapter 1

INTRODUCTION

This descriptive study focuses on the current practice of the nurse-midwifery profession which seeks more autonomy and more consensus on role and functions, practice arrangements, and professional relationships in the United States today ("AMA Survey discovers," 1995). This study explores several components of nurse-midwifery to illustrate and clarify how new graduates can accommodate to their own communities in an unstable, changing health care system (Starck, 1995). Nurse-midwives from a specific geographical area were interviewed for this study.

Background

Certified nurse-midwives (CNMs) are educated in two disciplines: nursing and midwifery, and possess evidence of the American College of Nurse-Midwives' (ACNM) required certification (Varney, 1987).

The practice of nurse-midwifery encourages continuity of care; emphasizes safe, competent clinical management; advocates non-intervention in normal processes; and promotes health education for women throughout the childbearing cycle. This practice may extend to include gynecological care of well women throughout the life cycle. (ACNM Brochure, 1989, p. 1)

Nurse-midwives provide extensive counseling and education in an effort to empower women to be in control of decision

making in their health care. This education is specific for health promotion, disease prevention, and alternative choices regarding procedures, tests, and medications. Nurse-midwives are specialists in the normal physical and psychological reproductive processes. They also possess knowledge of necessary emergency care in the absence of the consulting physician (ACNM Brochure, 1989).

Historically, nurse-midwifery in this country was born out of a need to improve maternal and child health. Mary Breckenridge recognized this need in the remote, rural areas of the Kentucky mountains in 1925. She brought nurse-midwives from England to provide health care to this underserved population (Varney, 1987). Mary Breckenridge's career was admirably suited for the task she initiated and undertook. She was professionally educated as a registered nurse in the United States and as a state certified midwife in England. Her family background allowed her influential contacts, and a carefully designed observation and study program in Scotland and England helped bring her plan to fruition in Kentucky (Varney, 1987).

The first nurse-midwifery education program in the United States was started in 1931 by the Maternity Center Association (MCA) in New York City with the direct help of Ralph Waldo Lobenstine, MD, Hazel Corbin, RN, and Mary Breckenridge who were on the board of directors at MCA.

All of the midwifery education today can be traced to

MCA's School of Nurse-Midwifery because all schools with the exception of the program at the Frontier Nursing Service have been started by either graduates or students of graduates of the MCA program.

(Varney, 1987, p. 21)

The MCA's creation of district health centers with nurse-midwives providing prenatal care was directly linked to the public health movement to decrease infant and maternal mortality. The development of community-based prenatal care clinics, along with well child clinics staffed by public health nurses, illustrates the early efforts by both nursing and midwifery to meet maternal and child health needs in an ambulatory setting.

Reviewing some of the early American nurse-midwifery careers, it is interesting to note the work of one important nursing theorist, Ernestine Wiedenbach. Nickel, Gesse, and MacLaren (1992) write that Wiedenbach's career spans five decades, the 1940s thru the 1990s, and includes accomplishments in prepared childbirth education, family-centered maternity care, nurse-midwifery education, and nursing theory. Her pioneering contributions to the practice of nurse-midwifery and education were recognized when the ACNM adopted an expanded version of her philosophy in April, 1961. According to these authors, she remains active in the field and continues to write and advise students to this day.

Another admirable career worthy of mention is that of Hattie Hemschemeyer, a public health nurse educator who in 1931 was named director of the Lobenstine Midwifery Clinic and School, later to be renamed Maternity Center Association School of Nurse-Midwifery (Varney, 1987). Hemschemeyer became a nurse-midwife with the first graduating class of the school in 1933. Hemschemeyer was not only a public health nurse educator and a nurse-midwife, but also the first president of ACNM (Varney, 1987).

The skills of a large percentage of the first nurse-midwives in this country were not utilized initially in the clinical field due to a lack of clinical nurse-midwifery opportunities. Additionally, CNM leaders did not want the CNMs to be perceived as competing with physician colleagues. Rather, these pioneering nurse-midwives met the needs for hospital-based nursing supervisors, consultants in both federal and international health organizations, and educators of maternity nursing (Varney, 1987). However, CNM's were also involved with public health institutions, giving care to the indigent and underserved, and with missionary work. Then, in the early to mid 1970s, nurse-midwives again responded to the needs of the community under the influence of the women's movement and consumer/childbirth education movement as they demanded change. CNMs began practicing in their own private

practices or with physicians, or both.

Problem Statement

Since 1925, nurse-midwifery in the United States has been attempting to establish itself autonomously from the medical profession. The trials and tribulations inherent in establishing an autonomous profession are intertwined with the role and functions of nurse-midwives. The career paths and future plans of qualified nurse-midwives reflect their perceptions of the profession. These perceptions play a key role in the acceptance of the profession by all concerned (i.e., nurses, physicians, and the general public). The research problem is a lack of clarity about nurse-midwives' career patterns and a lack of consensus among both providers and clients regarding the role and functions, practice arrangements, and professional relationships of nurse-midwives.

In the state-regulations for nurse-midwifery practice in California, there are several references to a supervising physician, which cause further confusion. The word "supervising" needs to be deleted from the state regulations, according to Susan Jenkins, JD, ACNM general counsel (personal communication, October 20, 1994), because the politicians who read these codes find it difficult to understand nurse-midwifery as a separate, autonomous, and independent profession. The medical profession's establishment of itself as central definer of care in all

aspects of health care--not just pathology--also serves to confuse the issue.

Purpose

The purpose of this descriptive study was to explore the perceptions of career patterns and future plans of five nurse-midwives who are practicing in the San Joaquin Valley of central California. These perceptions describe their role and functions, practice arrangements and professional relationships. Further, this study sought to define the role and functions, practice arrangements, and professional relationships of these nurse-midwives in the wake of an ever-changing national health care reform movement and a simultaneous emphasis on advanced practice nursing within the nursing profession. In order for nurse-midwifery to become its own autonomous profession, definitions of what CNMs do must be clearly articulated in the political arena and to the public at large. By providing an answer to the question of what these nurse-midwives believe about their career patterns, graduating students and new nurse-midwives may be able to make thoughtful and conscious decisions about their new careers. These nurse-midwives will be better prepared and have less surprises regarding their practices in the real world.

Research Questions

The phenomenon of investigation is the practice perceptions of five practicing nurse-midwives in a central

California valley city. The sensitizing questions or queries include:

1. What are the role and functions of a nurse-midwife?
2. How does the practice arrangement (i.e., solo, with other nurse-midwives, with a physician, or as an employee of a hospital) influence a nurse-midwifery practice?
3. How do nurse-midwives perceive their relationships with other health care providers (i.e., professional nurses, nurse practitioners, obstetrician/gynecologists, pediatricians, anesthesiologists) in the community?
4. What barriers are there to the role and functions, practice arrangements, and professional relationships of nurse-midwives?

Summary

In summary, the research problem and questions, when answered by nurse-midwives from a specific geographical area, will endeavor to provide guidance and leadership for inexperienced nurse-midwives as they journey into communities of their choice. The following chapter includes the conceptual framework and review of related literature.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

Conceptual Framework

The purpose of this study is to determine the perceptions of career paths and future plans of five female California nurse-midwives practicing in the central valley. The study used a naturalistic framework, in which the researcher primarily used the inductive process.

The conceptual framework of this study was provided by Ernestine Weidenbach, the interactionist nursing theorist (Meleis, 1991) who also used the inductive process in the development of her "prescriptive theory." The conceptual framework of Weidenbach's nursing theory directly relates to the perceptions of the nurse-midwives in this study.

Weidenbach's concept of prescriptive theory identifies the patient's need-for-help through the nurse's observations in determining inconsistencies (deviations from normal) (Meleis, 1991). Weidenbach's theory consists of three components which are the need-for-help, the action taken to resolve the need, and the acknowledgment of the action by both the nurse and the patient. Ministrations or actions toward the need-for-help is the central purpose of her nursing theory (George, 1980). George describes the third concept of Weidenbach's theory as the validation of the action from the central purpose, which must come from the patient as well as the nurse.

The role and functions of nurse-midwives include observing the patient/client for deviations from the normal. For example, if a pregnant woman's blood pressure begins to rise along with evidence of protein in her urine and edema of her hands and face, these deviations from a normal prenatal period are a need-for-help. These deviations provide for the next step which is to determine the action necessary to correct the deviation. Weidenbach would call these ministrations. Some of the ministrations in this example might be bedrest, increased fluid and protein intake, and daily blood pressure checks. The outcome of the action taken determines the validation. If the blood pressure stabilizes or decreases, the protein in the urine disappears, and the edema subsides, then the patient's improvement becomes the validation of the action. Both the patient and the nurse-midwife acknowledge these actions.

Weidenbach focuses on the nurse-patient interactions and regards the patient from a holistic point of view (Marriner, 1986). This interaction and view are provided by nurse-midwives and are central to their successful client advocacy. This advocacy is evident throughout the practice arrangement and professional relationships developed in a CNM's practice. Weidenbach's career as a nurse-midwife provided background and information to create her nursing theory, which is especially relevant to the role and

functions of a nurse-midwife.

Weidenbach's theory is related to this study in the three dimensions of: (a) the need-for-help to scrutinize the nurse-midwifery profession regarding its need for autonomy and independent management, (b) the actions of the nurse-midwives to determine their role and functions, practice arrangements, and professional relationships, and (c) the new nurse-midwives' adjustments as they begin participating in the profession of nurse-midwifery.

Literature Review

Findings from studies support the advantages of nurse-midwifery care. However, it has yet to be determined whether or not nurse-midwives are accepted as independent health care providers in all areas of this country.

Role and Functions

When differences in beliefs and philosophies of care between nurse-midwives and physicians (MDs) are studied, the findings are consistent. The differences are found in their beliefs concerning appropriate approaches to prenatal and intrapartum care (Yankou, Petersen, Oakley, & Mayes, 1993). According to this study, CNMs tend to favor management with ambulation in labor, discharge under 24 hours, mother's choice of position for delivery, and fathers present in the delivery room, although MDs rated the last variable as being even more important than CNMs did. Additionally, MDs rated pitocin, IV fluids, only ice

chips or nothing by mouth during labor, and labor analgesia/anesthesia more important than CNMs did. This study also found that CNMs do significantly more prenatal teaching and education than MDs.

The relationships between CNMs and MDs are important to the community's feeling of safety with nurse-midwives. According to Vosler and Burst (1993), there are two diverse effects from a health care system insisting on physician consultation, collaboration, and referral for practicing midwives. "One effect has been the intended one of assuring physician involvement when needed for the benefit of the patient" (p. 297). In contrast, the second effect, placing nurse-midwives in a position of dependency upon the physician, has been negative and unintended. This dependency leads to loss of ultimate power and control and influences whether or not a nurse-midwife can practice in a given community. This dependency sends a strong message that CNMs are unsafe without supervision by a physician (Vosler & Burst, 1993).

Some of the proposed solutions to cultivating mutual respect between nurse-midwives and obstetricians include educating physicians about nurse-midwifery, emphasizing nurse-midwifery's unique contributions and special skills, and establishing the fact that the nurse midwifery profession is complementary to, not competitive with, a physician's practice (Burgin, 1992).

Practice Arrangements

There are practice settings and models which are incorporating these suggestions already. Medical schools are giving CNMs appointments on their school faculties to provide clinical and classroom instruction to medical students and residents. These nurse-midwives participate as full members of the team in conferences, rounds, and seminars at these medical schools (Burgin, 1992).

Awareness and use of nurse-midwives by a community include several different practice models. The two most common models are the team model and partnership model. Scupholme and Camacho-Carr (1993) surveyed nurse-midwives at the 1993 annual ACNM meeting to assess the practice models being provided by CNMs. Three hundred twenty-seven participants representing 44 states, reported that 59% utilized the team model, which is nurse-midwives practicing with family-practice physicians, OB/GYN physicians, and nurse practitioners. Nearly all of the rest (37%) practice in a partnership with a physician. Other models may be CNMs providing only labor and delivery care employed by health maintenance organizations, providing home birth services, and practicing in state-funded and university based clinics.

The 1990 and 1991 ACNM surveys of members reveal that almost one half of employed CNMs were employed primarily by physicians and hospitals (Lehrman, 1992; Walsh & DeJoseph,

1993). A 1994 California survey of employed CNMs shows that 41% were employed by physicians and hospitals; an additional 17% work for a health maintenance organization (Judson & Flanagan, 1994). Based on these three studies, California CNMs are representative of the CNMs in other states in terms of practice models.

The ACNM surveys (Lehrman, 1992; Walsh & DeJoseph, 1993) and the California survey (Judson & Flanagan, 1994) also describe the client profile and practice site of CNMs. Over half of the CNMs provide care for over 100 clients per month. Sixty-seven percent principally serve clients of low socioeconomic status, and 66% serve women of low health risk status. There was an even distribution among inner city, suburban, and rural settings. Of women in vulnerable populations (poor, adolescent, part of a minority ethnic group, of immigrant status, or living in medically underserved areas), 99% of CNMs responding to a study indicated caring for at least one group, "and CNMs serving the inner city and rural populations provided services to women with several of these characteristics" (Scupholme, DeJoseph, Strobino, & Paine, 1992).

There are several barriers to some of the practice arrangements mentioned. Nurse-midwives citing barriers to rural practice in an Arizona study (Gordon & Erickson, 1993) identify the lack of physicians for consultation, collaboration, and referral as the most prevalent barrier

to rural practice. The lack of hospital privileges (admitting, discharge, and delivery), physician opposition, and lack of malpractice insurance were also cited as important barriers to practice (Gordon & Erickson, 1993).

Professional Relationships

In order to dispel some barriers to practice within the nurse-midwifery profession, CNMs need to claim the partnership role (with the woman-client) for which they are known (Flanagan, 1993). Internally, the profession's lack of consensus about a nurse-midwife's role and autonomy adds to the confusion for nurse-midwives. Externally or outside of the profession, particularly in California, two licenses (registered nurse and nurse-midwife) are required to practice. This requirement plus state-imposed limitations on prescriptive authority and inequities with regard to third party payments to nurse-midwives also add to the confusion over the roles for nurse-midwives and the public they serve.

Despite these barriers and obstacles, nurse-midwives make a considerable difference in perinatal health according to the statistics. From the early 1980's, "the literature reports favorable outcomes when nurse-midwives provided care to childbearing families" (Schorfheide, 1982, p. 12). Six studies are cited by Schorfheide (1982) supporting these findings that nurse-midwives benefit childbearing families. Schorfheide's 5-year study shows

decreases in low birth weight deliveries, perinatal deaths, and Cesarean section rates when care is provided by nurse-midwives instead of physicians.

The favorable comparison of clinical expertise and client outcomes between CNMs and physicians acknowledges and empowers CNMs, enlarging their legitimacy and respect from the public. Flanagan (1993) states, "Nurse-midwifery is not just cost-effective and as good as obstetric care, it is demonstrably better . . . " (p. 248). Clients rate higher satisfaction with nurse-midwifery care due to the greater amount of information (education) provided and a sense of shared control in labor and delivery. The differences reported are fewer numbers of low birth weight babies born with nurse-midwifery care, fewer perinatal deaths, and fewer Cesarean section births (Flanagan, 1993).

The nurse-midwifery philosophy of care guides CNMs to validate women's emotional and spiritual strengths by being "with woman," to develop rapport for interpersonal relationships, and to provide empathetic counseling. The ACNM statement of philosophy of care emphasizes that every individual has the right to safe, satisfying health care. This includes a respect for human dignity and cultural variations (ACNM, 1989). Additionally, many CNMs prefer to offer alternative health care practices to their clients. These practices include homeopathic care with teas, as well as herbs, tinctures, acupuncture, touch, body massage,

visualization, and imagery (Fullerton, 1994).

Trends in Nurse-Midwifery Careers

In the 1990 and 1991 ACNM surveys, there are several trends in nurse-midwifery careers. One trend was a large decrease in those CNMs living outside the country, who were involved in missionary work. Lehrman (1992) states that in the former ACNM surveys of 1985, 1986, & 1988, 46-48% of those living outside the continental United States were involved in missionary work. However, in the 1990 survey only 12.5% of those living outside this country were involved in missionary work (Lehrman, 1992). In other words, many of the United States prepared CNMs who are living and working outside the United States, are doing so in different capacities other than missionary work. However, these surveys do not answer questions such as what career patterns are taking them out of the United States and whether or not dissatisfaction or barriers to practice in the United States are factors.

Several other trends in CNM practice arrangements in the United States are noted in recent literature. One trend among CNMs is the decrease in the number of home births by CNMs, a consequence most likely due to lack of malpractice insurance coverage for nurse-midwives practicing home births (Walsh & DeJoseph, 1993). Another finding is that only 93.6% of nurse-midwives attending births are credited on the birth certificate as the birth attendant (Lehrman,

1992). The other 6.4% in Lehrman's study indicated either a physician was credited, another person was credited, or there was missing data. This reporting requirement significantly skews the accuracy of state and national statistics, in particular the outcomes of CNM deliveries.

According to a 1992 survey (Walsh & DeJoseph, 1993), another recent trend has been that CNMs' income continues to rise even in light of current economic stressors. Lastly, one other finding was that nearly one-half of the respondents to a survey characterized their practice as "midwifery-medical" as opposed to "mostly midwifery" or "more midwifery" (Judson & Flanagan, 1994).

The literature illustrates that the nurse-midwifery profession receives direction from the leadership of the American College of Nurse-Midwives. The ACNM has been the professional organization for nurse-midwives since its incorporation in 1955 (Varney, 1987). The ACNM has specific standards for the practice of nurse-midwifery which all CNMs must follow. These standards and the ACNM guidelines, which include establishing a nurse-midwifery practice, obtaining hospital privileges, and incorporating new procedures into a nurse-midwifery practice, help establish the ACNM in the leadership role of the development and promotion of high quality health care for women and infants. Other administrative and leadership aspects from the ACNM are clinical practice statements and position

statements, which are continually revised and approved as the profession requires. The ACNM represents nurse-midwifery's political, legal, and social definition and agenda, education, and scope of practice (Vosler & Burst, 1993).

Because of the tension among CNMs, the medical profession, and the nursing profession, practicing nurse-midwifery today requires that one is a strong, assertive advocate for women and their families (Vosler & Burst 1993). Nurse-midwives continue to be a positive force in today's practice of women's health care.

The effectiveness of nurse-midwives has been statistically proven again and again since the first studies at the Frontier Nursing Service, reproven again in the Madera County Demonstration Program in California, shown in every practice where nurse-midwives have worked, and again dramatically shown in the team concept which decreased by half the infant mortality in Holmes County, Mississippi, in 1971. (Varney, 1987, p. 34)

Chapter 3

METHODOLOGY

The purpose of this study is to provide information on the role and functions, practice arrangements, and professional relationships of nurse-midwives in order to better inform advanced practice nurses, specifically nurse-midwives. The questions for this study include those to address the variables of interest, i.e., role and functions, practice arrangements, and professional relationships, which are found in the interview guide (Appendix C). This chapter discusses the design and methodology of this study.

Research Design

The naturalistic, nonexperimental research design used to gather these data was a cross-sectional design in which the nurse-midwives were interviewed at one point in time. Two of the strengths of this design are the holistic perspective of data gathering in the natural environment of the interviewee and the interactive, dynamic data collection process between the researcher and interviewee (DePoy & Gitlin, 1994). According to DePoy and Gitlin, the weaknesses of this type of research design are the potential for (a) bias and personal perspectives of the researcher, and (b) inadequate steps taken to enhance the credibility and rigor of the investigation. The interview guide (see Appendix C) was used with the five subjects.

Sample and Setting

This study used a convenience sample specific to a certain geographical area. The subjects for this study were five practicing nurse midwives who have chosen different and varied career paths within this area. The setting was chosen because it reflects the dramatic growth and increase in the nurse-midwifery profession in a typical mid-sized city. The northern California city has a population of approximately 170,000 people and major industries of dairy, wine, and agriculture. The ethnic mixture includes 80% Caucasian, 15% Hispanic, 2-3% Cambodian, Laotian, or Vietnamese, and 1% African American.

The setting for these interviews was the subject's home, providing convenience and privacy. "The natural settings in which people under study live, work and play are sought for the conduct of the study" (LoBiondo-Wood & Haber, 1990, p. 185). For this study, that meant that going to the nurse-midwives' homes was an appropriate naturalistic setting because they are nurse-midwives 24 hours a day.

Instrument

The interview guide (Appendix C) gathers information relating to the general categories of role and functions, practice arrangements, and profession relationships of the nurse-midwives. This guide was developed by the researcher using the California CNM profile (Judson & Flanagan, 1994)

and the two national surveys of CNMs in 1990 (Lehrman, 1992) and 1991 (Walsh & DeJoseph, 1993) as sources of information.

Data Collection

The subjects were solicited through a phone call obtaining their agreement to be interviewed for this study. The interviews were taped with the subjects' permission and then transcribed at a later date. Data were collected in the privacy of the interviewees' homes. Each interview lasted between 1 and 2 hours. Permission was granted by the Human Subjects Institutional Review Board at San Jose State University to conduct this study.

Data Analysis

Data gathering and analysis are interdependent processes in naturalistic design (DePoy & Gitlin, 1994). Analysis in this way is an interactive, on-going, dynamic process in which the interviewer makes "on-the-spot" decisions from continuing analytic activity. DePoy and Gitlin (1994) state that this type of analytic strategy during the conduct of research and at its conclusion transforms the observational data into meaningful categories or themes to explain meaning and underlying patterns of certain phenomena.

Categories pertaining to the role and functions, practice arrangements, and professional relationships of nurse-midwives were made from the transcribed data. Data

were coded for specific variables under each category
pertinent to this study.

Chapter 4

FINDINGS AND INTERPRETATION

This chapter includes the results of data analysis of five subjects' interviews using the open-ended questions in the instrument of Appendix C. The results answer the sensitizing questions regarding the role and functions of nurse-midwives and their perceptions of the influence and barriers of practice arrangements and professional relationships on their nurse-midwifery practice.

Demographic Description of Subjects

The demographics of the five female nurse-midwives interviewed as the subjects of this study include the following data. All were between the ages of 40 and 51 years, four were married and one was divorced; they all had 2 or 3 children from ages 8 to 22 years. Their diverse educational backgrounds included four out of five with baccalaureate or higher degrees. The highest degrees attained were Associate of Arts in Nursing, Bachelor of Science in Chemistry and Biology, Bachelor of Science in Nursing, Master of Arts in Education, and Master of Science in Nursing. Four practiced as nurse practitioners either before their midwifery training or during graduate school. All five subjects obtained their midwifery training through certificate programs.

One subject is Hispanic and speaks Spanish fluently, while the other four are Caucasian with varying degrees of

Spanish language skills. The length of time practicing as a nurse-midwife ranges from 6 months to 10 years. All subjects currently practice midwifery with clinic or office hours of 2 to 5 days per week.

Role and Functions

The majority of the clients cared for by the five subjects are low to medium-risk females who are pregnant. If high-risk factors appear, the nurse-midwife makes the professional judgement that physician involvement becomes necessary. Depending upon the severity and control of the risk factors, the nurse-midwife will collaborate or co-manage that client with the physician. The age range of the clients is 2 to 90 years with the majority being during childbearing ages generally between 14 and 44 years. CNMs also see gynecological clients, which accounts for the wide range of ages. These subjects see between 80 and 300 clients per month, depending upon the number of days and hours in the office. One subject stressed that she wants 1 hour for a new obstetric client, 30 minutes for each postpartum visit, and between 15 and 30 minutes for return prenatal visits. She also thinks that between six and ten deliveries per month is a full-time load. These numbers vary with the number of days worked per week and are more ideal than realistic; therefore, they are not always achieved in day-to-day practice.

The cultural and racial diversity in these nurse-

midwifery practices closely mirrors the population of the area, which is 60-85% Caucasian, 15% Hispanic, 10% Southeast Asians, and 1-5% African-American. The percentage of low socioeconomic clients, with or without Medi-Cal insurance, varies from 10 to 60% among the subjects, and three will only accept those that are pregnant. The subjects describe little difficulty with language or cultural barriers. The innovative measures the subjects use to provide good care to culturally distinct clients are using interpreters who come in person with the client, including the clients' children, and telephoning a resource center for interpretation. Three out of four of the non-Hispanic subjects have adequate Spanish language skills to provide care to Spanish-speaking clients.

All of the nurse-midwives provide full-scope nurse-midwifery care, which means that they follow the client from the antepartal period through delivery. They also assess, plan, and treat not only the physical aspects of pregnancy, but the nutritional, exercise, lifestyle habits, psychosocial, and health education aspects of pregnancy, too. Although the subjects provide holistic care for a pregnant client, newborn care, circumcisions, and abortions are not performed.

The five subjects have rarely assisted at Cesarean sections; however, the area hospitals are in the process of writing standardized procedures for this function which

would allow the subjects to perform this procedure. Each nurse-midwife stated that she follows her Cesarean section clients into the surgery suite and stays with them throughout the procedure. The ability to continue providing support to these clients is very important to the nurse-midwives. Occasionally, two of the subjects provide infertility work-ups, colposcopies, or endometrial biopsies; however, these functions often depend upon the practice arrangement with the employing physician.

Practice Arrangements

The practice arrangements of these subjects include (a) one subject with one OB/GYN physician, (b) one subject with two OB/GYN physicians, and (c) a group of three subjects, one nurse practitioner, and five OB/GYN physicians. All five subjects are employees and not partners with these physicians. When queried about the adequacy of their compensation or salary, the subjects describe a general consensus that their salary and benefits are adequate for the geographical area. But they are uncomfortable about salaries when hourly wages are figured. One subject commented, "I don't think we are well enough paid for what we do. We are well paid for what mid-level practitioners are being paid, but not when you break it down into hourly wage." Benefits include malpractice insurance for all five subjects and health insurance for four of the subjects, with the exception being the subject

who works only part-time. She does not receive educational time, vacation time, or sick days. Depending upon how long the subjects have been employed, they negotiated vacation times, which are from 1 to 3 weeks per year. Paid sick leave days are accrued a certain number of hours per pay period. Benefits for education also vary; three subjects get paid time off, while one has her expenses reimbursed.

Only one subject has a Medi-Cal provider number and uses it to bill the Comprehensive Perinatal Services Program offered to all clients with Medi-Cal insurance. This same subject is the only one who has applied for and obtained a furnishing number for non-narcotic prescriptions.

When asked about their ideal practice arrangements in this community, three subjects expressed serious interest in a free-standing birthing center employing only certified nurse-midwives, nurse practitioners, and physician assistants, with telephone contact or perhaps a daily or weekly consultation by a physician. These subjects believe that they could tailor their practice to "mostly midwifery" in this environment. A fourth subject believes her present practice arrangement of practicing with two other CNMs and five physicians is ideal and the fifth subject believes full-time employment as a CNM would fulfill an ideal practice arrangement for her.

Professional Relationships

In requesting consultations with their physicians, all of the subjects report a great deal of support and no resistance. The subjects describe the physicians' increasing trust in the decisions made by them. When more than one physician might be available to collaborate or consult, the subject knows which to approach to get the answer she desires. The subjects also trust the conscientious, detailed approach of the physicians when conferring with them, because these MDs request rationale and a plan of action to ensure safety for the client.

When the subjects are questioned about how easy it is to consult and collaborate with on-call OB/GYN physicians other than their employing physicians, all say these physicians are even more patient and willing to be of service. The subjects believe that family practice doctors see them as competition; however, these doctors are more than willing to refer their pregnant clients to nurse-midwives if the clients return after the pregnancy. Only a few family practice physicians in this area practice obstetrics due to the high cost of malpractice insurance.

Each subject in the study has a different opinion of her relationships with the labor and delivery room nurses. Previous experience as a labor and delivery room nurse or FNP, or the degree of nurse-midwifery expertise are identified as factors which these five subjects believe

promote trust/respect from the nurses. One subject admits, I think they love it. Because of the downsizing of the hospitals, you know that every labor and delivery nurse is now overworked. So, when they hear it is a nurse-midwife patient, they love it because they know that we spend more time with our patients and they don't have to watch the patients.

There is a consensus among the subjects that time is needed for these nurses to build trust, to learn the CNM policies at that hospital, and to know the role and functions of CNMs in general.

Another potential professional relationship for the subjects in this city is with the family practice residents. These physicians are affiliated with a major university in California and complete a residency at a local hospital. The subjects' experience with the residents ranges from no interest at all to delivering nearly all of the babies born to the families of the residents. These residents seem to lack the time or inclination to learn from the subjects delivering babies at this hospital.

All subjects are in agreement that the general public still has little idea what nurse-midwives do and how they are different from an obstetrician. The need for constantly educating the public is a continuous function of the nurse-midwife whether in the grocery store or providing health care for clients at the office, according to the subjects.

Some of the suggestions from the subjects about starting a practice are to do research in local demographics and need for nurse-midwifery, to join a group nurse-midwifery practice, and to advertise. Their advice for a new nurse-midwife is to talk with other nurse-midwives in the area and negotiate fair salaries and benefits in order to not sell herself short. One subject states,

Have a low profile . . . with professional people . . . in dealing with your patients, you have to understand it is going to take a while to develop who you are; like getting to know them and talking through it, so they get to know who you are.

Another subject advises, "Be very astute to legal issues. Make sure you are very thorough and write down what you have done and what you have said." She suggests documenting all telephone calls, including those from one's home.

In summary, these five subjects perceive the role and functions of CNMs to include continuity of care, low to medium-risk, diverse clients, and extensive client education for promotion of health. The practice arrangements they describe with physicians vary as do the salaries and benefits. These subjects report collegial, trusting relationships with MDs, but inconsistent relationships with nurses, and an unawareness of nurse-midwifery by the general public. These findings and

interpretation will be discussed in Chapter five.

Chapter Five

DISCUSSION

This chapter discusses the findings, conclusions, scope and limitations of this study, and recommendations for further research and for certified nurse-midwifery practices.

Summary of Findings

This study aims to provide guidance and leadership for inexperienced nurse-midwives by answering the sensitizing questions regarding the role and functions of CNMs, their practice arrangements, and their professional relationships. Caring for women of all ages with continuity of care is the highest priority for the subjects of this study. The practice arrangements, hospital policies, state regulations, and insurance companies all influence the role and functions of a nurse-midwife. The CNM in private practice with a physician has less autonomy as an employee than a CNM who chooses to practice alone with an agreement to consult, collaboratively manage, or refer to a physician. Ideally, most of the subjects would prefer a birthing center setting in practice with other CNMs, nurse-practitioners, and physician-assistants.

The professional relationships of these subjects are characterized as peers with their employing physicians and "on-call" community OB/GYNs; however, relationships are less than ideal with the labor and delivery room (L & D)

nurses. Conflicts between these professional nurses (CNMs and L & D nurses) resolve as L & D nurses gain increasing knowledge of the role and functions of nurse-midwives, which creates trust and respect. Additionally, as CNMs, who have never been an L & D nurse, gain knowledge and respect for the labor and delivery room nurses' role and functions relationships will become smoother. Possibly, some of these tensions arise from professional nursing's actions and position statements that don't recognize nurse-midwifery as a unique discipline.

The study subjects' advice for a new nurse-midwife includes (a) assessment of the need for nurse-midwifery in the geographical area of interest, both from the general public and the medical profession, (b) astute negotiating to gain desired benefits from potential employers, and (c) clear, concise, and thorough client record documentation. Barriers to practice identified in the study include an inability to obtain (a) full hospital admitting privileges, (b) malpractice insurance, and/or (c) an agreement with a physician for consultation, collaborative management, or referral.

The subjects of this study reported inequities between their salaries and the hours they worked as a nurse-midwife. The hourly wages computed with the office hours, the on-call time, and the time spent attending labors and deliveries were inadequate, according to the subjects.

Conclusions

The subjects' perceptions of their salaries as insufficient compensation may very well add to the burnout and attrition rate of their clinical practice as nurse-midwives. This suggests possible loss of long-term professional identity.

According to Williams (1995), primary women's health care focuses on comprehensive assessment and management of common health problems in women. "All clinicians who provide health care to women . . . [are] held responsible for their contribution to the provision of acute and chronic care, health promotion, and coordination of referrals" (Williams, 1995, p. 58). Being a primary care provider as a CNM, which is demanded by managed health care reform, employing physicians, and the clients themselves, also creates a confusion in the practice of nurse-midwifery. Fullerton (1994) reports this confusion, "Respondents (CNMs) elaborated on the many common health concerns that CNMs encounter during their care of women, including both physical and psychosocial issues" (p. 107). Delivering primary care to their clients, with the possibility of having attended a nurse-midwifery program which did not fully prepare them for complete holistic primary care, may add to the stress of the role and functions of CNMs.

Obstacles to practice identified in this study are

being changed at the state level for California. SB 255 is a bill in the California legislature emphasizing the necessity of eliminating the word "supervising" from the relationships of CNMs to physicians in the nurse-midwifery statute. When passed, this bill will help create more autonomy for the nurse-midwifery profession by allowing them to practice independently in consultation with physicians as their education prepares them. In addition, prescriptive authority law for nurse-midwives needs to be enacted in the California legislature in order that CNMs can write non-narcotic prescriptions for their clients, providing more autonomy for the CNM profession.

The lack of collegiality between nurse-midwives and other nurses is disturbing. The team approach and appreciation for each others' specific skills, as is often demonstrated in CNM-physician relationships, needs to be developed among all health care providers. The CNMs can continue to build trust and respect between themselves and L & D nurses in the hospital situation.

The role and functions of nurse-midwives will need adjustments due to fewer prenatal visits, fewer or no routine sonograms, and the need for home care, which are changes being demanded by managed-care and capitation health care reforms. The nurse-midwife will also need to make adjustments in time schedules, client care, and personal lifestyle. Exactly what those changes will be

remains to be seen.

Scope and Limitations

This study was limited by sample and design. Because the sample is small and from only one geographical area, the subjects may not represent all CNMs. The basic purpose of naturalistic research is exploration, understanding, and description, and there was little ability to control for extraneous variables (Depoy & Gitlin, 1994). Therefore, the findings should be generalized with caution.

Recommendations

Further research recommendations are the use of a larger sample and in a different geographical location. Replication of this study could focus on CNMs as providers of (a) primary health care, (b) health care in the managed-care/capitation environment, (c) home birthing practices, and (d) private birthing-center practices.

Recommendations for inexperienced nurse-midwives beginning practice are: to (a) appreciate their own skills and profession, (b) arrange their practice to fit their own needs, thereby avoiding burn-out, and (c) use all resources, including other CNMs, available to them.

REFERENCES

References

AMA Survey discovers NPs perform with 'medium to high autonomy'. (1995, February). [AJN Newsline...]. American Journal of Nursing, 95(2), 76, 80. [Nurse Practitioner Extra].

American College of Nurse-Midwives (ACNM). (1989). Facts: Philosophy of the American College of Nurse-Midwives (Revised and approved, 1989) [Brochure]. Washington DC: Author.

Burgin, K. (1992). CNM/MD relations: Cultivating mutual respect [Editorial]. Journal of Nurse-Midwifery, 37, 81-83.

DePoy, E., & Gitlin, L. N. (1994). Introduction to research. St. Louis: Mosby.

Flanagan, J. (1993). Speaking up and talking out: Barriers and obstacles to nurse-midwifery practice. Journal of Nurse-Midwifery, 38, 246-251.

Fullerton, J. T. (1994). Reflections on nurse-midwifery role and functions. Journal of Nurse-Midwifery, 39, 107-109.

George, J. B. (1980). Nursing theories: The base for professional nursing practice. New Jersey: Prentice-Hall, 93-107.

Gordon, I. & Erickson, J. R. (1993). Comparison of rural and urban certified nurse-midwives in Arizona. Journal of Nurse-Midwifery, 38, 28-34.

Judson, K. & Flanagan, J. (1994). [California Nurse-Midwives Association: California CNM profile]. Unpublished raw data.

Lehrman, E. J. (1992). Findings of the 1990 annual American College of Nurse-Midwives membership survey. Journal of Nurse-Midwifery, 37, 33-47.

LoBiondo-Wood, G. & Haber, J. (1990). Nursing Research. St. Louis: Mosby.

Marriner, A. (1986). Nursing theorists and their works. St. Louis: Mosby.

Meleis, A. (1991). Theoretical nursing: Development and progress. (2nd ed). New York: Lippincott.

Nickel, S., Gesse, T., & MacLaren, A. (1992). Ernestine Wiedenbach: Her professional legacy. Journal of Nurse-Midwifery, 37, 161-167.

Schorfheide, A. M. (1982). Nurse-midwives and obstetricians: A team approach in private practice revisited. Journal of Nurse-Midwifery, 27, 12-15.

Scupholme, A., & Camacho-Carr, K. (1993). CNMs and primary care: Practice models and types of service. Quickening, 24, 14.

Scupholme, A., DeJoseph, J., Strobino, D. M., & Paine, L. L. (1992). Nurse-midwifery care to vulnerable populations phase I: Demographic characteristics of the national CNM sample. Journal of Nurse-Midwifery, 37, 341-348.

Starck, P. L. (1995). Health care reform in '95: Six problems APNs must address. American Journal of Nursing, 95 (1), 16E-16H. [Nurse Practitioner Extra].

Varney, H. (1987). Nurse-Midwifery (2nd ed.). Boston: Blackwell Scientific, 19-34.

Vosler, A. T., & Burst, H. V. (1993). Nurse-midwifery as it reinforces and transforms the American ideology of gendered roles. Journal of Nurse-Midwifery, 38, 293-300.

Walsh, L. V., & DeJoseph, J. (1993). Findings of the 1991 annual American College of Nurse-Midwives membership survey. Journal of Nurse-Midwifery, 38, 35-41.

Williams, D. R. (1995). Primary care for women: The nurse-midwifery legacy. Journal of Nurse-Midwifery, 40, 57-58.

Yankou, D., Petersen, B. A., Oakley, D., & Mayes, F. (1993). Philosophy of care: A pilot study comparing certified nurse-midwives and physicians. Journal of Nurse-Midwifery, 38, 159-164.

APPENDIX A

Human Subjects-Institutional Review Board Approval

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

TO: Samara Kemp
3904 Cougar Place
Modesto, CA 95356

FROM: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies & Research

DATE: April 25, 1995

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Career Patterns of Nurse-Midwives in a Specific
Geographical Area"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Serena Stanford, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.

APPENDIX B
Agreement to Participate

CAREER PATTERNS OF NURSE-MIDWIVES IN A
SPECIFIC GEOGRAPHICAL AREA
AGREEMENT TO PARTICIPATE

I understand that I am being asked to participate in a research study. My participation in this study on career patterns and future plans of the nurse-midwives in my area of practice will involve being interviewed for approximately 1 to 2 hours. The questions will be about my career as a nurse-midwife, my perception of practicing in the San Joaquin Valley of California, and what my future plans may be. The results of this study will help to clarify the status of nurse-midwifery in a central California valley city. This information will be useful for new graduates in this area and for other nurse-midwives looking for employment or practice.

My consent is being given voluntarily without being coerced. I may decline to answer any question or questions. I may withdraw from the study at any time without prejudice to my relations with the community at large, the medical community, or to any relationship I may have with San Jose State University.

I understand there is no risk in participating. There is no direct benefit except for having participated in a research study. I will not receive any compensation for my participation. Results of this study will be available to

Subject's Initials _____

participants upon request.

The information I provide will remain confidential. This information will be used for scientific purposes only. It will be published in a form in which I can never be identified as an individual. I will not be identified by name.

Any questions I might have about my participation in this study will be answered by Samara I. Kemp (209) 578-0872. Any complaints about the research procedures may be presented to Dr. Bobbye Gorenberg, Chair of the Nursing Department at San Jose State University, (408) 924-3130.

For questions or complaints about research subject's rights, I may contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, (408) 924-2480.

The signature of the subject on this document indicates agreement to participate in this study. The signature of the researcher on this document indicates agreement to include above named subject in the research and attestation that the subject has been fully informed of her rights.

_____
Subject's Signature

_____
Date

_____
Investigator's Signature

_____
Date

APPENDIX C
Interview Guide

Interview Guide

Demographics

What is your age?

How many years have you practiced as a nurse-midwife?

Are you married, single? Number of children, ages?

Tell me about your education - nursing training, midwifery education and college.

Role and Functions

What are some of the characteristics of your practice?

Describe your clients? High risk, low risk? How do you determine risk? Has that changed over the years? Number of clients you see per month. Age range of clients.

Percentage of low-socioeconomic clients.

What is the composition of your practice in regard to tasks and functions? Do you consider yours a full-scope nurse-midwifery practice? Preconceptual counselling? Newborn care for the first year? Infertility work-ups? Colposcopies? Endometrial biopsies? Norplant insertions? Circumcisions? Abortions? First assist for cesarean sections?

What is the racial or ethnic composition of your practice?

Are there any language or cultural barriers? Resolution?

Practice Arrangements

What is your practice arrangement? Where do you deliver babies?

How would you practice ideally in this community?

What is keeping you from practicing exactly the way you like?

Is the salary/compensation adequate for your area? Do you have health insurance, malpractice insurance, vacation/sick leave and education time provided in your practice arrangement?

Tell me about your furnishing/prescriptive authority?

Do you have your own MediCal provider number or does your office bill under the physician's number?

Are you a Comprehensive Perinatal Services Program provider?

Professional Relationships

How does it feel to consult with your physician?

When there is a difference of opinion, how do you resolve it?

Tell me about the labor and delivery room nurses and their attitude towards your management? How knowledgeable are they about the profession of nurse-midwifery?

How do other community physicians see your role? How are you viewed by the family practice residents?

Are the on-call physicians reluctant to consult or collaborate with you? If so, how is this resolved?

Tell me about your acceptance in this community? Do you find the general public knows what a nurse-midwife does and how she differs from an obstetrician?

What would you change about how you started your practice
of nurse-midwifery in this community?

What advice would you give a new nurse-midwife?

Are there any areas or questions that I didn't cover which
you'd like to address?