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INTRAPARTUM NURSES' BELIEFS ABOUT CHILDBIRTH: A DESCRIPTIVE QUALITATIVE STUDY IN NURSES THAT PROVIDE CARE TO WOMEN IN LABOR AND BIRTH

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INTRAPARTUM NURSES' BELIEFS ABOUT CHILDBIRTH:
A DESCRIPTIVE QUALITATIVE STUDY IN NURSES THAT PROVIDE CARE
TO WOMEN IN LABOR AND BIRTH

BY
SYLVIA P. ROSS

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Abstract

In the United States, a large gap exists between what is known as best evidence in maternal-newborn health and the routine practices at the frontline of maternity care. Intrapartum nurses are uniquely positioned to promote practices that are evidence-based and support the normal physiologic process of birth. This qualitative study explored intrapartum nurses' beliefs about childbirth and the influence of their beliefs on their clinical practice, particularly practices that promoted normal physiologic birth. Semi-structured qualitative interviews were conducted with 10 intrapartum registered nurses using Rubin and Rubin's (2012) responsive interview model. All participants practiced on a labor and delivery unit within an academic teaching hospital. Interviews were audio-recorded and transcribed verbatim. Initial descriptive codes were identified through open coding. Data was coded using Atlas.ti 6.2 and analyzed using qualitative descriptive analysis. Participants described five underlying beliefs. The beliefs included (a) childbirth is a profound event in a women's life, (b) providing care to women in childbirth is rewarding, (c) women should be supported in their choice for the type of birth that's right for them, (d) women's satisfaction with their birth is important, and (e) intrapartum nurses are experts in the care of women in labor and birth. These five beliefs affected the way in which participants provided care to women during labor and birth. Factors external to the participants' beliefs were also identified which influenced nursing practice. They included the establishment of safety, the organizational culture, patient satisfaction, and characteristics of today's childbearing women. These factors challenged the participants' beliefs and affected nursing care.

In summary, the five underlying beliefs identified by the participants were challenged by factors that influenced the way in which they were able to provide evidence-based nursing care. These factors were identified as barriers to woman-centered nursing care, particularly nursing care practices that support and promote normal physiologic birth. Future research is recommended to explore the impact of external factors to nurses' beliefs, with emphasis on the culture of the health care organization and childbearing women's expectations related to the quality and safety of intrapartum nursing care practices.

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Dedication

For my dear younger brother Dana, whose birth story was my first. You are sorely missed.

Table of Contents

Abstract	ii
Acknowledgments	iv
Dedication	vi
Table of Contents	vii
List of Tables.....	x
Chapter I Introduction	1
Maternity Care in the United States	1
Intrapartum Nursing Maternity Care.....	7
Purpose of Study	10
Study Design	10
Significance of Study for the Discipline of Nursing.....	10
Interest in Research Topic.....	12
Chapter II Literature Review.....	14
Introduction	14
State of Maternity Care	15
Historical Background for Childbirth and Normal Physiologic Birth	21
Definitions and Supporting Statements for Normal Physiologic Birth.....	28
Evaluation and Measurement.....	44
Lamaze Healthy Birth Practices.....	48
Intrapartum Nursing Maternity Care.....	50
Conclusion	53
Chapter III Methodology.....	56

Qualitative Research Methods	56
Purpose and Research Design	56
Participants	58
Data Analysis	63
Ethical Issues and Efforts at Enhancing Credibility	65
Chapter IV Findings and Discussion.....	69
Language and Terms Used in Interviews.....	70
Findings.....	70
Research Question One.....	70
Research Question Two	80
Research Question Three	86
Research Question Four.....	123
Discussion	132
The woman in labor and birth.....	143
Organizational factors affecting nursing care.....	149
Normal physiologic birth	153
The 1st Care Practice	154
The 2nd Care Practice.....	155
The 3rd Care Practice	155
The 4th Care Practice.....	156
The 5th Care Practice.....	157
The 6th Care Practice.....	157
Chapter V Summary, Conclusion, Limitations and Implications	160

Summary	160
Conclusions.....	167
Limitations	170
Implications.....	172
Future research.....	172
Theory development	174
Nursing education.....	176
Administration	178
Nursing practice.....	179
Appendix A Qualitative Interview Guide	180
Appendix B Recruitment Letter	186
Appendix C Consent Form for Research	189
Appendix D Contact Information Form.....	193
Appendix E Brief Demographic Questionnaire	194
Bibliography.....	197

List of Tables

Table	Page
Table 1 <i>Categories and Sub-categories used for coding</i>	65

Chapter I

Introduction

Historically and cross culturally pregnancy and childbirth have been considered a profound experience in a woman's life. It is an intensely physical and emotional event, and a woman's perception of her birth experience can be critical as she transitions to motherhood. For the majority of women, pregnancy and birth is a normal, healthy event and has the potential to be an empowering life experience (Shah, 2006).

Maternity Care in the United States

In the United States (U.S.), the maternity care system has two opposing views of childbirth, the medical model of childbirth and the physiologic model of childbirth (Goer & Romano, 2012). The medical model is a process of care based on the biomedical model of disease. In maternity care, the medical model considers childbirth a high-risk, pathological condition, which is fraught with risk and potential danger, and is referred to as the medicalization of childbirth in the literature (Kennedy, 2010). It is a model where childbirth is centered on the health care provider, institutional staff and routine policies and procedures. It is a view of birth that relies on the use of technology and medical intervention (Kennedy, 2010).

Conversely, the physiologic model also referred to as normal physiologic birth (NPB) views childbirth as a healthy, normal event in a woman's life. This model is not merely the absence of technical intervention or pathology, it is a holistic approach to pregnancy and childbirth. It places women at the center of care, promoting physical,

emotional and social well-being, fostering wellness and healthy adaptation to pregnancy, labor, birth and breastfeeding.

The perception of childbirth as a natural, physiologic process has been marginalized in the U.S. The medicalization of childbirth is the dominant paradigm in the current maternity health care system. High cesarean delivery rates, unnecessary technological intervention, and regional anesthesia have become the norm. Diony Young (2009), a nationally known educator, consultant and advocate for maternal and child health, describes the cultural definition and experience of childbirth in North America as one that is fundamentally grounded in philosophy framed by medical technology and intervention. Davis-Floyd (1992) maintains that while childbirth has been a rite of passage for women in non-western cultures, in westernized cultures, particularly the U.S., childbirth has been de-ritualized by a technology-based society. Kennedy (2010) asserts that a foundational fear of labor and birth has become the template for obstetrical care in western culture. The author points out that not only have women become fearful of childbirth, health care providers have as well. NPB has become jeopardized by the rising use and dependence on technology and intervention around the world. Many of the interventions available to women today have the potential to interfere with the normal birth process.

The medical model of birth supports the convenience of elective induction of labor, active management to accelerate the process of labor, and anesthetic pain relief with regional anesthesia. This model of care is popular in today's maternity care system. Today's generation of childbearing women bring a different set of values to labor and birth in the 21st century. Twenge (2006) describes today's post baby boomer

generation as the *me generation*. It is a generation characterized by self-importance. Today's generation of childbearing women are also very comfortable with the use and presence of technology in their lives.

In the U.S., almost 99% of the approximately 4 million births each year occur in a hospital setting (Albers, 2005). Childbirth is the most common reason for hospital admission in the U.S. healthcare system (Stapleton, Osborne, & Illuzzi, 2013). Approximately 85% of births are low-risk, healthy and without complications at the onset of labor in the U.S. (Albers; Sakala, 2006; Stapleton, Osborne & Illuzzi). However, one in three women gives birth by cesarean delivery (a surgical procedure used to deliver a baby through an incision in the maternal abdomen). According to a National Vital Statistics Report, the cesarean delivery rate for 2012 was most 32.8% (Osterman, & Martin, 2014), reflecting a meager decrease from 32.9% in 2009, a record high. For further perspective, the cesarean delivery rate in 1996 was 20.7%. From 1996 to 2009 the rate exponentially rose almost 60% (Martin, Hamilton, Ventura, Osterman, Kirmeyer, Mathews, & Wilson, 2009). Some hospitals in the U.S. have reached cesarean delivery rates of 50 percent and others are also headed in this direction (Davis-Floyd, 2006). This alarming statistic is of great significance in view of evidence demonstrating cesarean delivery is associated with higher rates of maternal and neonatal morbidity and mortality compared to vaginal birth (Deneaux-Tharaux Carmona, Bouvier-Colle, & Bréart, 2006; Kuklina et al., 2009; Miesnik & Reale, 2007; Villar et al., 2007).

Increasingly, some women in today's obstetrical system are either contemplating elective cesarean delivery or are offered cesarean delivery by their

health care providers for non-critical reasons. Campbell (2011) cites evidence supporting non-emergent elective cesarean delivery is associated with risks such as bladder injury, hemorrhage, post-surgical pain, deep vein thrombosis, delayed maternal-infant bonding, difficulties establishing breastfeeding, and increased length of hospital stay. Long-term problems associated with postpartum recovery involve readmission for post-op complications, infection, fatigue related to surgery, and continued difficulties with breastfeeding. Co-morbidities with subsequent pregnancies related to primary cesarean section such as placenta previa and placenta accreta also exist (Cambell). Increased incidence of infant respiratory problems, childhood asthma and chronic allergies are also associated with cesarean delivery (Sakala, 2006).

Operative deliveries play only a part in the medicalization of childbirth. Other unnecessary interventions interfere with the physiologic process of birth as well. One of the most important contributions to the evidence supporting maternity care experiences of women in the U.S. are the landmark series of surveys, published by *The Childbirth Connection*. This non-profit organization is dedicated to improving the lives of women and their families through evidence-based practice, research and education. In 2013, they published the results of the third national U.S. survey *Listening to Mothers III* (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013). *Listening to Mothers III* builds upon two previous surveys, *Listening to Mothers I and II* (Declercq, Sakala, Corry, & Applebaum, 2006; Declercq, Sakala, Corry, Applebaum, & Risher, 2002). The third survey highlighted the maternity care experiences of more than 2,400 women, all of whom had given birth in a U.S. hospital in 2011 and 2012. Results of the

survey emphasized the need for continued attention to concerning trends surrounding the medicalization of birth.

The increased uses of technology and cesarean delivery have not significantly improved maternal and infant mortality. The Infant Mortality Rate (IMR), a strong indicator of the health of a nation reached a rate of 6.9 of 1,000 live births in the US in the year 2000. The U.S. IMR presently ranks 30th worldwide, falling from 12th place in the world over the last 50 years (MacDorman & Mathews, 2009). Today, the U.S. IMR shows a slow decline but remains higher than many other developed countries. In 2010, *World Health Statistics* (World Health Organization [WHO], 2010) reported 33 countries with maternal mortality rates (MMR) below the U.S. The Pregnancy Mortality Surveillance System reports since 1987, the MMR rose from 7.2 to a high of 17.8 in 2009 (www.CDC.gov). The maternal morbidity rates have also increased. Callahan, Creanga and Kuklina (2012) looked at severe morbidity rates during labor, birth and postpartum. While linking the high cesarean delivery rate with maternal morbidity rate was unintentional, the authors identified 13 indicators of severe morbidity, which were consistently associated with post-operative complications. The authors concluded that the increasing rates of maternal morbidity cannot be separated from the high rate of cesarean delivery, and further studies are needed. Marshall, Rongwei, and Guise (2011) conducted a systematic review (21 trials) and examined maternal morbidity and repeat cesarean deliveries. Findings supported progressive maternal morbidity with each subsequent cesarean delivery. This finding is significant in view of the substantial increase in repeat cesarean deliveries over the last two decades in the U.S.

The American College of Obstetricians and Gynecologists recently published an Obstetric Care Consensus Series, *Safe Prevention of the Primary Cesarean Delivery* (Obstetric Care Consensus No. 1, 2014). The authors emphasize that while the cesarean delivery rate has significantly increased, the increased rate has not been shown to improve maternal, infant or neonatal morbidity and mortality. The consensus statement recommends that all maternity care providers are responsible to identify safe and appropriate methods to avoid unnecessary use of cesarean delivery.

Technology and selective use of interventions in obstetrics has been shown to benefit women with complicated or high-risk pregnancy related conditions. In specific high-risk clinical situations, evidence clearly supports the use of electronic fetal monitoring (EFM), induction of labor, epidural anesthesia and cesarean delivery. In the U.S., the maternity care has become a system designed to care for all pregnant women as if serious medical and obstetrical problems exist. The challenge for maternity health care providers is to critically delineate which intervention(s) will improve birth outcomes versus which will potentially interfere with the normal physiologic processes of birth.

In an effort to understand the rising use of technology in the U.S. and around the world, an article titled, *Why Do Women Go Along with This Stuff?* was published in *Birth* (Klein, Sakala, Simkin, Davis-Floyd, Rooks, & Pincus, 2006). Expert maternity care professionals and childbirth advocates met in a roundtable forum. The focus of discussion was the current trends in the U.S. maternity care system. The panel had several questions of high importance. Are outcomes better because the culture of birth in the U.S. has become highly dependent on technology? Is the price of today's

attempts to control as much of life as possible worth the price for our mothers and babies? Simkin (Klein et al. 2006), a member of the roundtable discussion suggests the title, *Why Do Women Go Along with This Stuff?* implies the assumption that women in today's maternity system actually have choices. Simkin asserts that many women don't have the opportunity to make choices for a birth that best suits their needs, and the women that do have choices often place too much uninformed reliance on their doctors, i.e., "doctors know best" (p. 247). Sakala (Klein et al.), also a member of the round table, cited the acceptance of a technology-intensive culture, the lack of professional autonomy for nurse-midwives and family physicians in the obstetrical system, and an underlying cultural fear of birth as some of the reasons women accept the way maternity care is provided in the U.S.

There is an urgent need to reemphasize childbirth as a normal physiologic event in women's lives. Depersonalization of childbirth found within the inherent authority of the western medicalization of childbirth has created many barriers and constraints for women. These barriers are problematic for the women who view birth as a unique and individualized event and want to experience normal, physiologic childbirth.

Intrapartum Nursing Maternity Care

In the U.S., approximately 99% of births occur in a hospital setting (Boucher, Bennett, McFarlin, & Freeze, 2009) therefore a nurse is present at the bedside of almost every woman who delivers a baby in this country. Nurses are influential decision makers as they manage, support and provide direct clinical care to women and newborns. As frontline caregivers, intrapartum nurses are essential members of the

health care team and can participate in improving the quality of care that is provided to mothers and newborns across the U.S. Not only are intrapartum nurses pivotal for improving maternity care outcomes, they are uniquely positioned to promote, protect and support care practices that foster NPB.

While recognizing the unique position that intrapartum nurses hold in the maternity care system, Gagnon, Meier, and Waghorn (2007) suggest that patterns of intrapartum nursing care practices have been understudied, especially in relation to the medicalization and excessive use of interventions in today's maternity culture. The authors maintain that the over-use of technology in the maternity care setting over the last two decades has had a tremendous impact on nursing practice, potentially resulting in fragmented and impersonalized care.

More than half of the states have had an increase in home birth between 2004-2008 (Martin, Hamilton, Ventura, Osterman, Kirmeyer, Mathews, & Wilson, 2011). Boucher et al. (2009) maintains that the increase in settings (other than hospital) stems from the belief that home or freestanding birth centers are perceived to be places where NPB and the uniqueness of women are embraced. Women perceive these settings as a place where they are well supported, and can develop trusting and meaningful relationships with their caregivers.

In 2003, Lamaze International identified six evidence-based maternity care practices to promote NPB. Romano and Lothian (2008) believe that nurses are in a "unique position to provide these care practices and to assist childbearing women in making informed choices based on evidence" (p. 1). Kennedy (2004) maintains that nurses are the most likely group to bring about change in the hospital environment to

“support normal birth” (p. 559). The author emphasizes that nurses can guide and influence care practices in the hospital setting. Intrapartum nurses can support a practice environment that offers alternative activities compared to the typical routine interventions, which are so widely embraced by the medical model of care.

For childbirth, the normal physiologic process of birth has become the model that is the alternative approach, not usual way to give birth in the U.S. Reform of maternity care is at a critical juncture. In order to improve the quality of maternity care for women in our culture, we must listen to the voices from the frontline. Research to understand intrapartum nurses underlying beliefs about childbirth, factors that influence their beliefs and a more clear understanding of barriers and facilitators that hinder or support best practices will help to move towards an environment of care that is supported by evidence, and will support optimal and low interventive care to a majority of women in labor and birth.

Since nurses in the U.S. maternity care system are the most visible healthcare professionals attending women’s births, their role is pivotal in how women and families experience labor and birth. Carlton, Callister, Christiaens, and Walker (2009) suggest that the voice of the maternity care nurse should be examined and explored thoroughly. However, there is only a modest body of literature documenting nurses’ beliefs and perceptions about childbirth. In the U.S. and other developed countries, there is a gap in the literature specifically focused on nursing and NPB.

There are very few events in a woman’s life comparable to childbirth. It is an intensely physical and emotional experience, and often has an impact on the successful transition to motherhood and parenthood as well as the newborn’s adjustment to

extrauterine life. There is a significant body of evidence to support the benefits and safe outcomes for the normal physiologic model of birth (Goer & Romano, 2012). In the U.S. maternity care system, nurses are uniquely positioned to promote improvements in the maternity care system from the frontlines of care. Nurses have the potential to educate women, families, members of the interprofessional team, and the health care organization about the benefits of the physiologic model of birth.

Purpose of Study

The purpose of this descriptive, qualitative study was to explore intrapartum nurses' beliefs about childbirth. Its focus was to identify and describe the nature of intrapartum nurses beliefs, how these beliefs affect the way in which they provide nursing care, and what factors influence their clinical practice. Nurses' perceptions about NPB, and factors that support and hinder NPB practices were also explored.

Study Design

This study used a qualitative approach to explore nurses' beliefs about childbirth. Semi-structured, in depth interviews were conducted with 10 experienced intrapartum nurses employed at a large, urban maternity hospital in the northeast region of the U.S. A snowball sampling technique was used to recruit the study participants. Five underlying beliefs that intrapartum nurses have about childbirth were identified, as well as several factors that influence the way in which intrapartum nurses provide care to women in labor and birth.

Significance of Study for the Discipline of Nursing

It is important to explore intrapartum nurses' beliefs about childbirth, factors which influence beliefs and barriers to best nursing practice, in order to expand nursing

knowledge of the care of women in labor and birth. This research is situated within the domain of nursing practice.

Kim (2010) identified four conceptual domains to be used as a guide for knowledge development and theoretical frameworks in the discipline of nursing. The practice domain refers to the intellectual/cognitive, social, behavioral, and ethical aspects of care performed by nurses (Kim). How nurses use knowledge to transfer ‘what one knows’ to ‘what one does’ correlates with cognition to action, and undergirds the practice domain. In this domain, nursing knowledge is discovered through our understanding of how nursing actions affect the lives of clients by influencing outcomes, both positively and negatively. To improve nursing knowledge at the practice level, the purpose of this study was to gain a deeper understanding of nurses’ beliefs about childbirth, how these beliefs evolved, factors that influence the beliefs, and barriers and facilitators for nursing practice that support and promote NPB.

Kim (2010) makes the distinction between private and public nursing knowledge. Private knowledge is what the nurse knows individually, rooted in education, clinical, and personal experiences. Public knowledge is knowledge that is available and discussed in the academic setting. A ‘theory-practice gap’ occurs when the public sphere of knowledge doesn’t get translated to the private sphere of knowledge, or what is known in the literature (the evidence) is not translated to actual practice (the theory-practice gap). An excellent example of the theory-practice gap is the significant body of evidence supporting the benefits and improved outcomes associated with NPB. However, what is actually practiced at the patient care level is not consistently congruent with the evidence. The findings from this study will provide

a deeper awareness of the existing gap between intrapartum nurses' private knowledge and what is known as best evidence for nursing practice in the U.S. maternity care system.

Interest in Research Topic

As a nurse-midwife, I have had the opportunity to provide care to many women and their families during childbirth. I have practiced both on the traditional labor and birth unit and in the Alternative Birthing Center (ABC) in an academic, tertiary care hospital setting. In the ABC, members of the health care team (midwives, nurses, pediatricians, and collaborating physicians) recognized, supported, and promoted NPB. However, if circumstances required that a woman in labor be transferred to the traditional labor and birth unit, there were many challenges to continue the promotion and support of NPB.

After sixteen years of experience as nurse-midwife, I began to teach maternity and newborn care to baccalaureate level nursing students. The curriculum in the classroom was grounded in NPB. However, I seldom had the opportunity to provide students with clinical learning experiences to observe NPB because of the dominant medical-model of birth. High tech and highly interventive births provided the majority of the clinical learning opportunities for the nursing students. Students asked why the content taught in the classroom differed from what they were learning in the clinical setting. This highlighted a theory-practice gap. To address this question, I started with a review of the most current maternity nursing textbooks. I found that the textbook descriptions of nursing care for women in labor and birth were grounded in care practices that supported NPB. As part of a national interest group of nurse-midwives

who taught maternity nursing, I realized that the same issue was challenging other nursing faculty. A serious issue where there was a shortage of clinical experiences for students to learn about NPB.

As a nurse-midwife and nursing educator, it became evident that intrapartum nurses, the frontline health care providers who spend the most amount of time with women in labor and birth, can influence the process and outcomes for women and newborns.

Evidence suggests that the overuse of technology and intervention for low-risk women in labor and birth has the potential to place women and newborns at risk. In order to improve the quality and safety of maternity care, it is important to understand the beliefs and perceptions that intrapartum nurses have about childbirth. Research on this topic will provide a deeper understanding of the barriers and facilitators that nurses' experience as they practice in the maternity care system in the U.S.

There is an emerging body of literature to support the benefits of NPB for both women and newborns, however this literature is primarily written for a nurse-midwifery and obstetrician audience. There is a notable gap in the literature about intrapartum nurses' beliefs and perceptions of childbirth, specifically NPB and this is where the research for this study is focused.

Chapter II

Literature Review

Introduction

The U.S. maternity system is characterized by the overuse of technology and intervention, and the underuse of practices that have been shown to be beneficial for the safe and satisfying outcomes for women and newborns (Gee & Corry, 2012). The highest cesarean delivery rates ever recorded, unnecessary induction of labor, routine use of regional anesthesia, the physical separation of the mother and the newborn at birth and low breast-feeding rates are the consequences of maternity care in this country (Declercq et al., 2013).

While the medical model view of birth is founded on the expectation of complications there is ample evidence to support childbirth as a normal, healthy process for the vast majority of women worldwide (Goer & Romano, 2012; WHO, 2006). Lamaze International (2001) maintains that the safety of childbirth is enhanced by the promotion and protection of the normal physiologic process of labor and birth. Mead (2008) suggests: “It is time that professionals regain their trust in the physiology which enables healthy women to labour and deliver, mostly without interference. Pregnancy and labour should be seen as normal until proven otherwise” (p. 92).

The purpose of this literature review is to provide a comprehensive review of the current evidence surrounding three important topics: the state of maternity care in the U.S., NPB, and the pivotal role of intrapartum nursing care of women in labor and birth.

A structured literature search was conducted using the keywords childbirth, normal birth, labor and birth, intrapartum nursing, labor and delivery nursing, midwifery, cesarean section, cesarean delivery, medicalization of birth. CINAHL (EBSCO host), MEDLINE, PubMed, OVID, Cochrane Data Base, Google Scholar, and Dissertation Abstracts were used as the primary reference databases. Evidence from 1990 to 2014 was considered, in English only. The terms natural birth, normal birth, normal physiologic birth, normal childbirth, and physiologic birth are used interchangeably in the literature. The spelling of labor, as in pregnancy and labor is also spelled as labour, the old French version traditionally used in the literature emerging from the United Kingdom and Europe.

State of Maternity Care

Approximately 85% of pregnant women living in the U.S. are at low risk for complications (Stapleton, Osborne & Illuzzi, 2013), however at almost 33%, the cesarean delivery rate is the highest it has ever been (Hamilton, Martin, & Ventura, 2011). Not only is the cesarean delivery rate high, the intervention rate for low risk women is also unnecessarily high (Declercq et al., 2013). The medical model and the rising use of technology and unnecessary intervention have jeopardized the normalcy of physiologic birth.

Cesarean delivery is the most common surgical procedure performed today in the U.S. (Childbirth Connection, 2012; Russo, Weir, & Steiner, 2009). The cesarean delivery rate increased from 5% in the 1960s to 31.8% in 2007, and is presently 32.8%. The World Health Organization (WHO) recommends that the optimum rate for cesarean delivery worldwide should be 15% or less (Campbell, 2011). Cesarean

delivery rates above 15% are not associated with improved outcomes (Campbell, 2011; Declercq, et al., 2013) and have been shown to be associated with an increased rate of maternal morbidity (Althabe & Belizan, 2006; Ehrenthal, Jiang, & Strobino, 2010). While evidence supports that cesarean delivery is associated with considerable maternal and newborn morbidities, Stapleton, Osborne, and Illuzzi (2013) note that the cost for childbirth has become the single largest contributor to our national hospital health care costs.

Healthy People 2020 identify evidence-based national objectives to improve the health and well-being of all individuals in our nation. Two priority objectives are to reduce the rate of maternal mortality and reduce the cesarean delivery rate, (among low-risk women with no prior cesarean delivery), both by 10% by the year 2020 (Department of Health and Human Services, 2009).

MacDorman, Declercq, Menacker, and Malloy (2006) collected data from 1998 to 2001, from nationally linked infant birth and death data to determine the death rate of infants specifically born to mothers who were at low risk for complications. After controlling for variables such as gestational age, birth weight, parity, education level, smoking status, congenital anomalies, and Apgar scores (less than 4), the researchers found that infants born by cesarean delivery were 2.7 times more likely to die. This study is important because of the high rate of cesarean deliveries in the U.S. and in other developed countries.

Operative deliveries play only a part in the medicalization of birth. Other interventions potentially interfere with the process of normal physiologic birth as well. *The Childbirth Connection*, a non-profit organization dedicated to improving the lives

of women and their families through evidence based practice, research, and education, published the results of a third survey, *Listening to Mothers III* (Declercq et al., 2013). Building on the two previous landmark surveys *Listening to Mothers I and II* (2002, 2006), Declercq and colleagues (2013) found that while participants gave overall good ratings of the quality of care in the U.S. maternity care system, most women are still subject to routine interventions that are not supported by evidence. For example, 31% of all labors were medically induced with synthetic oxytocin and more than half of these women were induced for non-medical reasons. Overall, 87% of women had at least one of the big five interventions which include attempted labor induction, epidural, Pitocin augmentation, assisted delivery with vacuum or forceps or cesarean delivery. Sixty percent of these women had a least two of the five interventions listed above. All these interventions lack an evidence base for routine practice in low risk pregnancies and contribute to the current climate of the medicalization of birth, underpinning modern obstetrical care (Goer & Romano, 2012). While more women are choosing an elective induction of labor, evidence suggests that this procedure ties into the rising cesarean delivery rates, particularly for nulliparous women (Simpson, 2003).

Regional epidural anesthesia provides excellent relief from pain in childbirth. However, it is not without its risk and has the potential to interfere with the physiologic process of birth. The pelvic relaxation that occurs as a result of epidural anesthesia has the potential to prevent fetal rotation and descent (Anim-Somuah, Smyth, & Howell, 2005, Lieberman & O'Donoghue, 2002). A common side effect of an epidural is maternal hypotension, which not only has the potential to negatively affect maternal well-being but fetal oxygenation as well. Absence of maternal pain is

also connected with a decrease in the release of oxytocin which is the maternal hormone released to sustain uterine contractions for labor progress (Romano & Lothian, 2008). Augmentation of labor with synthetic oxytocin (Pitocin) is often necessary after the epidural is administered. There are many interventions that typically follow the administration of an epidural, most of them resulting in the limited ability for maternal movement and restriction to bed. Evidence supports that for first time mothers who receive an epidural, there is an increased risk of longer labors, cesarean delivery, and other types of instrumental deliveries (Anim-Somuah, Smyth, & Howell, 2005, Lieberman & O'Donoghue, 2002, Klein, 2006). Maternal fever is common with an epidural, and often requires newborn evaluation and potential treatment with antibiotics. Although the woman receives relief from the pain associated with labor and birth, these interventions must be monitored for potential complications and side effects.

EFM continues to be the most typical way of evaluating fetal well-being in the U.S., even though the evidence to support that EFM of low-risk women in labor does not improve outcomes for the mother or newborn (Alfirevic, Devane, & Gyte, 2013). EFM is the process of monitoring maternal uterine contractions and fetal heart rate during labor and birth. The simplest description of the purpose of EFM is that it is used to identify fetal hypoxia in order to intervene and prevent fetal asphyxia (Simpson & Knox, 2000). Introduced to obstetrical care in the late 1960s, EFM was intended to be used primarily for women with complicated and/or high-risk pregnancies in order to reduce the incidence of cerebral palsy (Simpson & Knox, 2000). However, the rate of cerebral palsy has remained steady over the last 30 years, and remains at

approximately 1 to 2 per 1000 live births (Pschirrer & Yeomans, 2000). Simpson and Knox (2000) assert that while EFM does have the potential to prevent fetal morbidity and mortality, “as a stand-alone tool, it is ineffective in avoiding preventable adverse outcomes” (p. 50).

With EFM, women are usually tethered to a machine and in bed but equipment is occasionally available for a wireless transmission if a woman desires to walk in labor. Either way, EFM can be cumbersome, preventing woman from moving into more comfortable positions to cope with painful contractions. It can prevent a woman from walking in labor or using hydrotherapy for comfort, both of which have been shown to support the normal progression of labor (Goer & Romano, 2012).

An alternative to EFM is intermittent monitoring. Intermittent monitoring assesses fetal heart rate with the use of a hand-held device (Doppler), or a tocometer attached to the EFM machinery, or a Pinard stethoscope. Intermittent monitoring allows for freedom of movement in every phase of labor. It is particularly helpful for position changes and hydrotherapy for pain relief (Alfirevic, Devane, & Gyte, 2013). The perceived drawback of this method is it gives information about the fetus intermittently rather than continuously.

In 2013, a systematic review of 13 randomized trials of 37,000 low and high-risk pregnant women compared continuous EFM to intermittent auscultation (Alfirevic et al, 2013). Results revealed no significant differences in perinatal mortality, NICU admissions or cerebral palsy. However, in many of the maternity settings across the country and the developed world, EFM is the typical method of assessment for all women in labor and birth. While EFM is a not a practice supported by evidence,

concern for medical liability is the underlying force that supports the routine use of this practice (Collins, 2008).

A U.S. and Canadian Task Force on Preventive Health Care (2005) recommend against the use of routine EFM for low risk women in labor and birth. The Royal College of Obstetricians and Gynaecologists recommends intermittent auscultation for low risk women and the American College of Obstetricians and Gynecologists (ACOG), recommends continuous EFM only in high-risk pregnancies. Intermittent fetal monitoring is an acceptable practice in uncomplicated patients (ACOG Practice Bulletin No. 106, 2009). Some researchers argue that the use of continuous EFM for laboring woman with no risk factors might be potentially harmful and can result in restriction of movement, unnecessary interventions and instrumental and cesarean delivery (Alfirevic et al., 2013). A Cochrane Review examined the common practice of collecting a baseline EFM strip for women in labor upon admission to the hospital (Devane, Lalor, Daly, McGuire, & Smith, 2012). Four trials, involving more than 13,000 women, showed there was no benefit to this practice.

Childbirth by cesarean delivery is slowly becoming accepted as a safe way to give birth. In *Listening to Women III*, Declercq and colleagues (2013) point out that while the cesarean delivery rate solely based on maternal request remains low, 22% of women reported asking their physician for a cesarean delivery and 87% of these women did so because they believed that it would be beneficial to them or their babies.

There is an urgent need to reintroduce childbirth as a normal physiological event in women's lives. Women should be encouraged and supported by each other and by their health care providers to trust in their bodies and believe in the healthy

process and optimal outcomes associated with NPB (Downe, 2008; Goer & Romano, 2012; Kennedy, 2004; Shah, 2006).

The inherent authority of western medicine and the medicalization of childbirth have created many barriers and constraints for women and their families who wish to experience childbirth as a safe and normal physiologic event (Morris, 2013). These constraints exist not only for women, but also for the healthcare providers (physicians, midwives, and nurses) who wish to care for women in labor and birth from the standpoint of normal (Downe, 2008; Morris, 2013; Romano & Lothian, 2008; Wagner, 2006).

Reliance on technology is evident in almost every aspect of modern day life, and often influences decision-making. Many women fail to understand the potential impact that unnecessary and routine interventions have on childbirth. Anthropologist Sheila Kitzinger, author of many books on the politics and status of childbirth writes:

In achieving the depersonalization of childbirth and at the same time solving the problem of pain, our society may have lost more than it has gained. We are left with the physical husks; the transcending significance has been drained away. In doing so, we have reached the goal which is perhaps implicit in all highly developed technological cultures, mechanized control of the human body and the complete obliteration of all disturbing sensations (Kitzinger, 1978, p. 133).

Historical Background for Childbirth and Normal Physiologic Birth

Downe (2008) asserts that childbirth today is guided by a philosophy that embraces the concept of authoritative knowledge, knowledge that is characterized by

dominance and authority. Rapp (1997) asserts that the framework for authoritative knowledge when related to birth is associated with the distribution of unequal power and hierarchies (i.e. physician dominated care and institutions), (Davis-Floyd & Sargent, 1997). Jordan (1997) claims that all participants of labor and birth should have the opportunity to have their voices heard and should be a part of the decision making process. Jordan questions what a world would look like if “mutual accommodation of these divergent ways of knowing were in place and legitimately contributed to the epistemology of childbirth” (p. 17).

According to Downe (2008), the nature of childbirth in industrialized countries is grounded by an epistemology that is framed by the 18th century European philosophy of science, emphasizing ideals of certainty, simplicity, linearity, and pathology. Evolving from science in the Enlightenment period, certainty and simplicity provide the foundation for revered science and research in the 20th and 21st century. It is best described as knowledge that is generated from a positivist construction, with ontology based in objective realism (Downe, 2008).

Philosopher and scientist Rene Descartes believed that the understanding of humans could be simplified and broken down into basic parts (Flew, 1979). Cartesian duality, the separation of mind and body, embodies the ontology of the Enlightenment period. The dominant scientific belief was that all human phenomena could be understood and explained. Human variation was dismissed as a confounding variable. Philosophers of science like Descartes focused on developing theories that were simple and allowed generalizations to the public. Generally, Descartes’ science was rooted in cause and effect, allowing for scientists to believe in one truth (Downe, 2008;

Goldberg, 2012). For example, consider the study of a specific aspect of the physiology of birth-the shape of a woman's pelvis-in relation to being able to give birth vaginally. This paradigm of science would take the study findings and generalize it to the general population, without addressing the bio-social-cultural complexity of labor and birth (Downe; Goldberg). Bateson, (1985) suggests that seeking the simplest, most attractive explanation is typical, parsimonious, and is an obligation of science. Today's scientific evidence is largely based on the promotion of randomized clinical trials, structured protocols, and results that can be generalized (Downe). As a science with roots in objectivity, the subjective lived experience of humans is unaccounted for.

In regards to the research and science on childbirth, Downe (2008) considers the positivistic way of thinking as grounded in certainty and linearity. Discounting the complexities involved in the event of childbirth allows for a very limited, authoritative, and rigid vision of NPB and suggests a more broadened view of science where clinical artistry is appreciated. Downe asserts that during the 18th century some philosophical and scientific communities were skeptical about such certainty and linear thinking. One example of this is German philosopher Immanuel Kant (1724-1804) who argued that empirical knowledge is largely dependent on the way it is perceived by the individual, therefore, not everyone experience things in the same way (Flew, 1979). Arguments like this challenged the assumptions of certainty, simplicity and linear thinking in science, questioning cause and effect and the role of the individual and their relationship within a system. Downe (2008) poses that instead of certainty, attempts should be made to utilize the principles of quantum physics, a branch of physics that embraces the idea that the natural world does not consist of simple and

predictable phenomena, rather it is complex and chaotic. Applying this idea to childbirth, the author suggests that instead of linearity, there is a web of interconnectedness, supporting the idea that there is no right way of doing things. Many women in labor do not progress in a linear, predictable fashion but in the end they are able to give birth in a healthy way that is normal for them. Coming back to a unique normality, honoring the individual on a bio-social-cultural continuum is what Downe (2008) considers as normal. This is also what promotes wellness, health and positive outcomes in all arenas of healthcare, not just maternity care. This view of practice is what Downe refers to as clinical artistry. Downe (2008) specifically emphasizes that her paradigm does not reject modern science or its contributions to improving the rates of maternal-infant morbidity and mortality throughout the world. Rather she proposes a shift away from the traditional, narrow, positivistic construction of science that guides modern evidence-based practice toward a more broadened view of science where the art of clinical practice (clinical artistry) is acknowledged as well. Discounting the complexities involved in the event of childbirth leads to a very limited, authoritative, and rigid vision of NPB.

There is an individual uniqueness that all women bring to childbirth that can be characterized as normal variation(s). These normal variations can include a wide range of common differences. Individual differences can be found in emotional well-being, nutritional status, sociocultural support, attitudes, beliefs, expectations, and conceptualization of birth. Normal variations are also seen in the size and shape of the maternal pelvis and the fetus. Even the length of gestation may vary from individual to individual. These are just a few of the many phenomena that have an effect on the

outcome of birth and our ability to sustain as a species. The term *unique normality* takes into account each woman's experience in labor from the context of her pregnancy, her family, her culture, her psychosocial and emotional history as she navigates labor and birth (Beech & Phipps, 2008; Downe, 2008).

As women are more and more constrained by the standards that embody today's modern obstetrics, critical theorists suggest that women giving birth have been fundamentally reduced to physical machines (Downe, 2008), or just physical bodies (Goldberg, 2002). While the randomized clinical trial is considered the gold standard of research, scientists must take into consideration the biological, sociocultural, and psychological aspects of human beings, especially where birth is considered. Downe (2008) does not suggest a rejection of science but encourages a more encompassing method of legitimate ways of knowing. To avoid the separation of the art and science, understanding of the complexities of normal birth generated from the hand, brain and heart, (p. 23) creates a more holistic approach to childbirth.

For more than half a century women have been bound to a system that supports a linear way of thinking when it pertains to the progression of labor. When inquiry and knowledge are framed within a linear context, a cause and effect relationship can be in place, implying that one event leads to another. The best example of this is the well-known Friedman Labor Curve (Friedman, 1955; Zhang et al., 2010). In the 1950s, Friedman developed a partogram based on the labor progress of almost 10,000 women. Although Friedman did not intend to become the authority for normal labor progress, his research became seminal in the world of obstetrics and became a labor progress tool that dictated labor management (Downe, 2004). Based on Friedman's Labor

Curve, many women were given medications to speed up labor or underwent a cesarean delivery when labor progress was too slow or had stopped (Downe, 2008; Obstetric Care Consensus, 2013; Zhang et al., 2010).

In an observational study of healthy women in labor Albers, Schiff, and Gorwoda (1996) concluded that normal labor progression is much longer than the progress demonstrated in Friedman's partogram. The author points out that longer labors are not associated with increased maternal and neonatal morbidity and recommends that labor length based on time alone needs to be reexamined.

The Consortium on Safe Labor (National Institute of Child Health and Human Development) funded a large multicenter, retrospective, observational study also examining normal labor progress. Zhang et al. (2010) collected and analyzed data from the electronic hospital records of more than 62,000 women. Results demonstrated that active labor was lengthier than originally believed. The authors suggested that a clinical practice that supports longer first stages of labor (before introducing interventions) would decrease the rate of primary cesarean deliveries. When comparing the two studies, Albers et al. (1996) study limited inclusion to women with the spontaneous onset of labor, without Pitocin augmentation and without epidural anesthesia. The Consortium on Safe Labor study included labors augmented with Pitocin and regional anesthesia. Almost 50% of the Consortium study participants received oxytocin for augmentation of labor, which may have shortened the length of labor. Both studies support that contemporary obstetrics needs to reexamine the definition of the normal length of the first stage of labor. The Obstetric Care Consensus (ACOG, 2014) recommends that the Consortium on Safe Labor data should

be considered as best evidence for labor management in place of Friedman's Labor curve. The statement suggests extending the time it takes for women to reach the active phase of labor may safely reduce the rate of primary cesarean deliveries (ACOG, 2014).

An organization consisting of individual and national consumers, *The Coalition for Improving Maternity Services* (CIMS) has adopted a model focused on well-being in childbirth as an alternative to high-cost screening and treatment programs. According to Wagner (2006) there are more than 90,000 members in CIMS. Their mission is "to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs" (www.motherfriendly.org). CIMS created a consensus document founded on maternity care for change. The *Mother-Friendly Childbirth Initiative* (MFCI) evolved in the 1990s with a focus on initiatives for change that promote a mother-friendly childbirth model of care in institutions in the U.S. and abroad. The principles of this model include birth as a normal, healthy event in a woman's life and women should be empowered and encouraged by every person who cares for her. Each woman should have access to a healthy and satisfying birth experience for herself and her family, regardless of her age or circumstances and should be supported to give birth as she wishes in an environment in which she feels nurtured and secure. The importance of evidence-based care is also emphasized in this model and it is recommended all maternity care should be based on evidence to support practice and decision making (<http://www.motherfriendly.org/MFCI>).

Definitions and Supporting Statements for Normal Physiologic Birth

Review of the literature related to the concept of NPB, specific definitions of NPB and care practices that support NPB will be discussed in the following section.

The concept of normal and normalcy in pregnancy and childbirth is the philosophical foundation for the midwifery model of care (ACNM Philosophy Statement, 2004; Davis, 2010; Downe, 2008; Gould, 2000; Murphy, 2004). A search for the meaning of the word normal frequently reveals words and phrases such as usual, typical or what is most common. Normal also correlates with words like regular, ordinary, healthy, and free of illness, as well as common, conventional, and the unexceptional. In physics, the word normal means that all particles are aligned or act in harmony (Gould). According to *New Oxford American Dictionary* (2010) normal is defined as adjective and a noun with unique but similar meanings.

As an adjective, normal is defined as conforming to a standard; usual, typical, or expected (of a person)... free from physical or mental disorders. As a noun it is defined as the usual, average, or typical state or condition. Such as “her temperature was above normal, the service will be back to normal next week, a person who is physically or mentally healthy” (New Oxford American Dictionary, 2010).

The term normal is rooted in our everyday life. Normal usually represents health and to some degree wellness, whereas the term abnormal refers to a condition or conditions that deviate from normal health (Crabtree, 2004). To deviate from what is considered normal often is labeled abnormal, a term that many people associate with illness, disease, and pathology. The dichotomous terms normal and abnormal are

mutually exclusive and are common concepts in our understanding of health and wellness in modern western biomedical culture.

Physiologic stems from the Latin word *physiologia* and is defined as a noun in the 2010 New Oxford American Dictionary. It is “the branch of biology that deals with the normal functions of living organisms and their parts: “the way in which a living organism or bodily part functions.”

In relation to childbirth, the construct of the word normal is in contrast to what typically takes place in the U.S. and developed countries across the world. In an editorial in the *Journal of Midwifery and Women’s Health*, Kennedy (2010) suggests that our culture is normalizing intervention in childbirth and marginalizing birth without technology. Kennedy upholds that the abnormal has become the normal and the normal has become the abnormal in the U.S. culture of birth. As a culture we are moving away from the idea that birth is a normal physiologic process that women are innately capable of. Many women have come to expect a conveniently scheduled, painless birth. Largely grounded in the worldview of birth as an event associated with pathology and disease, this approach often leads to complications, unnecessary interventions, operative deliveries and birth trauma (Kennedy). In the current health care system, what takes place normally is not necessarily based on evidence to support best practice (Kennedy). Mead (2008) suggests that in attempts to define normal physiologic birth, “it is time that professionals regain their trust in the physiology which enables healthy women to labour and deliver, mostly without interference. Pregnancy and labour should be seen as normal until proven otherwise” (p. 92).

A key theme throughout the literature when examining definitions of NPB is the variety of inclusions and exclusions of interventions. The nuances for the definition of normal birth differ between individuals, organizations and institutions. Through an increasing awareness of unnecessary interventions for the maternity care of low-risk women throughout the world, WHO (1996) emphasized the adoption of a standardized definition for normal birth in 1996. WHO convened a working group of health care experts from around the world. The final product of the working group was a document entitled “Care in Normal Birth: A Practical Guide.” The preamble of the document emphasized that this was the first time that childbirth experts from around the world had the opportunity to produce a document specifically based on current evidence and contemporary knowledge surrounding “good practice for the conduct of non-complicated labour and delivery” (p. 1). The preamble states:

Despite considerable debate and research over many years the concept of normality in labour and delivery is not standardized or universal. Recent decades have seen a rapid expansion in the development and use of a range of practices designed to start, augment, accelerate, regulate or monitor the physiological process of labour, with the aim of improving outcomes for mothers and babies, and sometimes of rationalizing work patterns in institutional birth. In developed countries where such activity has become generalized questions are increasingly raised as to the value or desirability of such high levels of intervention. In the meantime, developing countries are seeking to make safe, affordable delivery care accessible to all women. The uncritical adoption of a

range of unhelpful, untimely, inappropriate and/or unnecessary interventions, all too frequently poorly evaluated, is a risk run by many who try to improve the maternity services. After establishing a working definition of "normal birth" this report identifies the commonest practices used throughout labour and attempts to establish some norms of good practice for the conduct of non-complicated labour and delivery. (WHO, 1996, p. 1)

The following definition of normal birth is a result of the WHO working group.

Normal birth is defined as:

. . . spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, the mother and baby are in good condition . . . In normal birth, there should be a valid reason to interfere with the natural process. (WHO, 1996)

The WHO document discusses, in detail, procedures and evidence-based practice for the support of normal labor and birth in every stage of labor. Two important recommendations include skin-to-skin mother-infant contact immediately after birth and putting the baby to breast as soon as possible. The document has a classification system that seems to be a common thread (in slightly different formats) in several of the other more current definitions of normal childbirth in the current literature. The classification system includes:

1. Practices which are Demonstrably Useful and Should be Encouraged,

2. Practices which are Clearly Harmful or Ineffective and Should be Eliminated, and
3. Practices for which Insufficient Evidence Exists to Support a Clear Recommendation and which Should be Used with Caution while Further Research Clarifies the Issue. (WHO, 1996, p. 39)

This system is based on best evidence to support clinical practices associated with optimal outcomes for mothers and newborns.

Downe (2006) acknowledges the importance of developing a universal meaning of normal birth and recognizes that a common meaning for the term normal labor doesn't exist. Downe (2008) considers the WHO (1996) definition as the most popular description to which individuals refer to in the maternity health care system. However, she cautions that care should be taken to avoid creating yet another set of rigid standards that women in labor and birth must abide by.

Anthropologist Brigitte Jordan (Jordan & Davis-Floyd, 1993) maintains that how birth is conceptualized in a society is an important indicator of the health of the maternity system. Currently there is not a universal definition of NPB in the literature (Davis, 2010; Downe, 2006; Gould, 2000; WHO, 1996). Werkmeister, Jokinen, Mahmood, and Newburn (2008) assert that normal birth is more than a spontaneous vaginal birth, or the absence of an operative delivery. The authors challenge maternity health care professionals to join together to develop a clear understanding of normal labor and birth in order to better support women in childbirth both emotionally and physically. Creating a mutually agreed upon standard definition of normal birth will also improve the ability to measure women's childbirth experiences in order to

improve management of care, inform policy, trends, and factors that potentially affect outcomes (Werkmeister, et al., 2008).

In an editorial published in *Birth* (2009), Diony Young compares and contrasts the published policy statements and definitions of normal childbirth. WHO, the Maternity Care Working Party (MCWP) and the Canadian Joint Policy Statement (approved by the Society of Obstetricians and Gynecologists of Canada, [SOGC]), Association of Women's Health, Obstetrics and Neonatal Nurses of Canada (AWHONN, Canada), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC), the Society of Rural Physicians of Canada (SRPC) were reviewed. In addition to these organizations, the American College of Nurse-Midwives (ACNM) released a consensus statement supporting NPB in 2012. Bond (2010), points out prominent U.S. organizations such as ACOG, the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) and the American Academy of Family Physicians (AAFP) lack formal statements about normal childbirth. Although AWHONN doesn't specifically have a formal statement or a working definition of normal birth, the organization has adopted (and recommends) Lamaze International's (2003, 2009) Six Evidence-Based Care Practices. The six care practices can be implemented to support and promote normal birth (AWHONN press release, January, 2008).

In a concept analysis of unique normality in childbirth, Downe (2006) discusses the International Confederation of Midwives (2005) and their subtle change in the definition of the role of the midwife that includes the promotion of normal birth. The author suggests that although expertise in normal birth is foundational to

midwifery practice, the alarming rate of unnecessary intervention warrants the specific statement, even for midwives.

Downe (2006) asserts that there is a general lack of agreement about what is meant by normal childbirth. In an attempt to understand and clarify the various definitions of normal childbirth, she created three broad categories that delineate working definitions of normal childbirth emerging from various authoritative organizations. The first category is the focused unidimensional clinical definition. It is the most common, the broadest, and specifically focuses on the physical aspects of birth. Downe (2006) maintains that the WHO (1996) definition of normal birth is an example of a focused unidimensional clinical definition, which only incorporates the physiological aspects of childbirth. She further suggests that this definition is where most communication and discussion about normal birth takes place.

The second category is the focused multidimensional definition and includes clinical elements of birth in the definition and emphasizes that birth is a dynamic process involving the physical interactions between the mother and the fetus. This definition also considers the standards and procedures in the setting in which the birth takes place. The third category is defined as life course multidimensional and takes into consideration pre-pregnancy, birth and post-birth aspects. The author believes that when health care professionals work in “authentic partnership” (p. 356), exhibiting collegiality and respect, the experience of birth is likely to be more satisfying for both the woman and her family as well as the health care provider. There is a range of definitions that professionals and consumers use when discussing what they perceive to be normal childbirth.

Downe (2006) suggests that the WHO (1996) definition serves as a foundation for the other statements that evolved in the 21st century. The Maternity Care Working Party (MCWP), the Canadian Joint Policy Statement, and ACNM all draw from the WHO statement for defining normal birth.

The Maternity Care Working Party (MCWP) is an independent, multidisciplinary group of maternity health care professionals (the Royal College of Midwives, the Royal College of Obstetricians and Gynecologists, and The National Childbirth Trust), working to improve awareness of the rising rate of cesarean delivery in the United Kingdom (2007). The MCWP developed a consensus statement on normal birth. Similar to WHO (1996), the MCWP's definition includes a preamble on the importance of normal birth. The definition starts with a paragraph of what outcomes constitute a normal birth: a woman whose labour starts spontaneously, progresses spontaneously without drugs, and who gives birth spontaneously (MCWP, 2007). While very similar to the WHO definition, this consensus statement also included other parameters to define normal birth. Augmentation of labour, rupture of the membranes, use of EFM, and active management of the third stage of labour are examples of some of the practices included in this definition. Normal delivery excludes women who experience any one or more of the following induction of labour (with prostaglandins, oxytocics or artificial rupture of membranes), regional or general anaesthetic, forceps or vacuum-assisted delivery, caesarean delivery, or episiotomy (MCWP, 2007). The MCWP emphasizes the importance of data collection and dissemination of statistically significant trends on physical and psychological

morbidity associated with operative delivery rates, especially the elective and unnecessary cesarean delivery rates.

A third document to emerge is called the *Joint Policy Statement on Normal Childbirth*. This 2008 consensus statement emerged from the five leading organizations of maternity care in Canada. This included the Society of Obstetricians and Gynaecologists of Canada (SOGC), the Association of Women's Health, Obstetric and Neonatal Nurses of Canada (AWHONN Canada), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada, and the Society of Rural Physicians of Canada (SRPC). The consensus statement states:

A normal birth is spontaneous in onset, is low-risk at the start of labour and remains so throughout labour and birth. The infant is born spontaneously in vertex position between 37 and 42+0 completed weeks of pregnancy. Normal birth *includes* the opportunity for skin–skin holding and breastfeeding in the first hour after the birth. Normal birth may also include evidence-based intervention in appropriate circumstances to facilitate labour progress and normal vaginal delivery, for example: augmentation of labour, artificial rupture of the membranes if it is not part of medical induction of labour, pharmacologic pain relief (nitrous oxide, opioids and/or epidural), managed third stage of labour, non-pharmacologic pain relief and intermittent fetal auscultation. A normal birth does not preclude possible complications such as postpartum hemorrhage, perineal trauma and repair, and admission to the neonatal intensive care unit. A normal

birth *does not* include: elective induction of labour prior to 41+0 weeks, spinal analgesia, general anaesthetic, forceps or vacuum assistance, caesarean section, routine episiotomy, continuous EFM for low risk birth, or fetal malpresentation. (Joint Policy Statement on Normal Childbirth, Canadian Consensus Statement, 2008, p. 1163)

In addition to criteria already mentioned, the SOGC specifically recommends freedom of movement in labor and birth, continuous labor support, spontaneous pushing in the woman's choice of position and intermittent fetal monitoring. Additionally, the Canadian statement supports vaginal delivery after cesarean, which is not mentioned in the WHO (1996) or MCWP (2007) definition and statement.

Both the MCWP and the Canadian consensus statement include some aspects of the medical model of care. Within their definition they include augmentation of labor, amniotomy, pharmacologic pain relief, and active management of the third stage of labor. While the Canadian statement specifically excludes the use of continuous fetal monitoring, it does include epidural anesthesia. Conversely, WHO (1996) considers epidural anesthesia a "striking example" (p. 16) of the medicalization of normal birth. Both the MCWP statement and the Canadian statement do not address IV hydration in labor. The MCWP statement doesn't differentiate between continuous and intermittent fetal monitoring, which is a subtle but significant difference however the statement excludes regional and general anesthesia. All three of the definitions (WHO, MCWP, and the Canadian experts) exclude induction of labor, operative delivery (forceps, vacuum or cesarean section), and the routine use of episiotomy.

While the professional organizations previously discussed have developed their own definition of normal birth, it is clear that the definitions vary in inclusion and exclusion of specifically identified interventions. Young (2009) maintains that each country has different health care systems with individualized challenges to overcome.

Three U.S. midwifery organizations including ACNM, the Midwives Alliance of North America (MANA) and the National Association of Certified Professional Midwives (NACPM) recently collaborated to create a document entitled *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA and NACPM* (2012). This consensus statement was developed as a template for change in the delivery of maternity care in the U.S., providing a framework for the promotion and support of NPB. The foreword to the definition emphasizes the omnipresent use of technology and interventions in labor and birth and how it has become the normal in the U.S. culture of birth. Specific attention is drawn to the use of synthetic oxytocin, continuous fetal monitoring, the high rate of cesarean delivery, post-surgical complications, and interference with maternal-infant bonding. Access to maternity care that supports NPB (i.e. midwifery care) is underscored. The ACNM consensus statement definition is:

A normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus. This birth is more likely to be safe and healthy because there is no intervention with these normal physiologic processes. Some women and/or fetuses will develop complications that warrant medical attention to assure safe and healthy outcomes. However, supporting the normal physiologic processes of

labor and birth, even in the presence of such complications, holds potential to enhance best outcomes for mother and infant. (ACNM, 2012, p. 2)

Included in the ACNM consensus statement definition of NPB is the spontaneous onset and progression of labor, which includes biological and psychological conditions that promote effective labor resulting in the vaginal birth of the infant and placenta. Also included in the definition is that NPB facilitates optimal newborn transition through skin-to-skin contact, keeping the mother and infant together during the postpartum period, and the support of early initiation of breastfeeding (ACNM, 2012). This consensus statement identifies areas that disrupt normal physiologic birth such as induction or augmentation of labor, an unsupportive physical environment, and time constraints on lengths of stages of labor, epidural anesthesia, operative delivery, and immediate umbilical cord clamping. The consensus statement makes recommendations for a birth setting and environment that supports normal birth, the interdisciplinary education on evidence-based practice supporting NPB for all maternity care providers and an increase in the numbers of midwives attending births.

The following example is a focused multidimensional definition of normal birth (Downe, 2006). The Royal College of Midwives describe normal birth using the following definition:

Birth is a unique and dynamic process, where fetal and maternal physiologies interact symbiotically, (birth) occurs within 24 hours of commencement of labor, with minimal trauma occurring to either the

mother or baby. Birth is spontaneous onset between 37 and 42 weeks, and follows an uncomplicated pregnancy. (Downe, 2008)

This definition not only recognizes the physiological aspects of birth but also identifies the uniqueness and maternal-fetal symbiotic interaction associated with childbirth.

Myles Textbook for Midwives (Bennett & Brown, 1999) utilizes a life course multidimensional definition (Downe, 2006) to define normal birth: The Myles definition is: “The physiological transition from pregnancy to motherhood (which) heralds an enormous change in each woman physically and psychologically...every system in the body is affected and the experience represents a major *rite de passage* in the woman’s life . . .” (Myles as cited in Downe, 2006, p. 353).

Gould (2000) attempts to define normal birth in her concept analysis on normal labor. She emphasizes the importance of language when attempting to communicate ideas and disseminate knowledge. Gould’s definition of normal labor is simplistic and unidimensional (Downe, 2006). She specifically differentiates normal from abnormal in labor (Gould). Gould’s distinctions of abnormal are identified as artificial rupture of membranes, intravenous Syntocinon or Syntometrine (synthetic oxytocin) for induction of labour, episiotomy, and directed pushing. Her definition of normal labor includes:

Physiologically normal labour naturally follows a *sequential* pattern, the woman experiences painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and descent of the fetus, culminating in the spontaneous vaginal birth of a healthy baby and expulsion of placenta and membranes with no apparent

complications in mother or baby, it is strenuous work and physical movement has a crucial role. (p. 423)

Gould (2000) builds on the work of Marsden Wagner, a physician, author, and women's health advocate, which emphasizes the unique interprofessional perspectives and variations when defining normal birth. The obstetrician views birth as normal if there are no pathological abnormalities and no interventions. The epidemiologist views normal birth as normal when it takes place entirely naturally, but acknowledges that the medicalization of childbirth has made it difficult to measure. Psychologists believe birth is related to the woman's lifecycle and her transition through motherhood endorsing her progression towards full womanhood. Anthropologists maintain that the western society is progressively abnormalizing birth, and for the sociologist, birth is not a normal process but is a social process where the woman herself and her environment affect the outcome. Lastly, the midwife views birth as normal if it is perceived as normal for the woman, and fits her own frame of reference because birth is a uniquely individualized experience for women (Gould, 2000).

Gould (2000) identifies measurable parameters of normal labor and emphasizes the importance in modern midwifery practice. Rationale for limiting the definition of normal labor to a purely physical unidimensional definition stems from her criteria for defining the most common attributes which serve to isolate the concept so that it is recognizable and lacking in subjective interpretation (Gould). Gould believes that healthy pregnant women with a singleton vertex fetus at term gestation with no apparent complications are antecedents to normal labor. If all of these antecedents are

in place, a healthy mother and infant will potentially be the consequence of normal labor and birth.

Davis's (2010) concept analysis of normal birth is in contrast to Gould's unidimensional interpretation of attributes that define normal labor and birth and includes a life course multidimensional definition (Downe, 2006). The Davis definition is comprehensive, all-inclusive, and considers the sociocultural circumstances as well as the physiology of childbirth. The author points out that midwives clearly recognize the restraints of limiting the definition of the concept of normal birth to the physiological only aspect of the birth experience. She explores the meaning of normalcy in childbirth with a sample of 13 midwives (12 Certified Nurse Midwives and one Certified Midwife). The midwives collectively described normalcy in childbirth as:

An expression of a complex physiologic-psychologic process along wide, interpretive continuum, and includes both process and outcomes; meaningful within the context of the individual woman's nature, which includes both her physiologic capacity to give birth and her unique life circumstances; and is sensitive and responsive to environmental factors.

The midwives stipulated unanimously that normalcy in childbirth is grounded unequivocally on the well-being of the woman and her baby.

(Davis, 2010, p. 209)

Davis (2010) identified underlying dynamics in her definition of normal birth that contributed to the shaping of the concept. This included the physical space where women experience birth, as well as the attributes of the midwives. These attributes

included beliefs, attitudes, knowledge, skills, and intuitive knowledge. The results of this work help to define normal birth from a more inclusive and holistic viewpoint.

The participants in Davis's study identified five empirical referents of normal birth: spontaneous onset of labor, spontaneous progress in labor, and spontaneous birth, along with the woman's effective coping with birth and the woman's freedom and capacity to do whatever she needs to do to give birth to her baby. These referents stemmed from the clinical practice observations and support the multidimensional definition of normal birth.

Kennedy and Shannon (2004) explored the processes of midwifery care and related them to the achievement of excellent outcomes. Using narrative analysis to explore and describe the central processes of midwifery care, the authors found that midwives trust in the innate normal physiologic process of birth. This is central to the process of midwifery care. Findings from Kennedy and Shannon's study (2004) also support the importance of presence or *being there* with women in labor and birth. This serves as reassurance of safety and can help to prevent unnecessary use of interventions. A tolerance for wide variations of what is considered normal in individual maternity care cultures was also found to be a hallmark for midwifery care in this study. While Kennedy and Shannon (2004) didn't specifically define NPB, this study links the outcomes of midwifery care with an underlying belief in NPB.

In 1996, WHO convened to address the rising rate of cesarean delivery and increasing rates of unnecessary interventions used in during labor and birth. A WHO working group developed one of the first definitions of normal childbirth, and provided a foundation for other organizations to build from. Although the definitions of normal

birth, from organization to organization, vary, experts from around the world have recognized that research and strategies to decrease the cesarean delivery rate are necessary. Defining NPB is a place to start to identify key benchmarks for healthcare providers and consumers alike (ACNM, MANA & NACPM, 2012, Kennedy, 2010).

Evaluation and Measurement

The medical model of care measures obstetrical outcomes with a focus on pathology instead of wellness. Maternal and infant morbidity and mortality, rates of cesarean delivery and operative deliveries (forceps, vacuum extraction), regional anesthesia, labor inductions, postpartum hemorrhage and puerperal infections, poor Apgar scores are all examples of benchmarks that define our nation's maternity outcomes. This is in direct contrast to dissemination of information to the public on the rates of spontaneous onset of labor, successful vaginal deliveries, non-anesthetized births, and successful breastfeeding upon discharge and at the six-week follow-up visit. Soo Downe (2008) makes the point that, "there is no point in assessing wellness since it does not need to be treated, and therefore it is not of interest to health services" (p. 11).

Based on the assumption that the majority of women who give birth in the U.S. are low risk, Murphy and Fullerton (2006) and ACNM (2006) developed a unique, innovative instrument to measure the quality of maternity care. The tool is known as Optimality Index-US. Midwifery care is grounded in the philosophy of care that supports "advocacy of non-intervention in the absence of complications" (Murphy & Fullerton, p. 1), and midwifery has been associated with improved outcomes for low risk mothers and newborns (Cragin & Kennedy, 2006; Kennedy & Shannon, 2004;

Rooks, 1999). Based on the premise that childbirth is a normal physiologic event in a woman's life, the Optimality Index-US is an instrument that measures the processes of care provided by nurse-midwives. The instrument's score lowers as more interventions are introduced. It focuses on the frequency of optimal events (positive outcomes) versus the traditional focus on adverse outcomes.

Khalil et al. (2005) examined 44 hospital-based obstetrical services in Egypt over a 28-day period. Clinical practices rather than outcomes were measured. Using the WHO (1996) classification of care in normal birth, a multidisciplinary approach was used to collect data on common normal labor practices and evidence-based care. Practices that preserved and supported normal birth were infrequent. Unexpectedly high levels of harmful practices lacking sufficient evidence were prevalent. When the maternity care providers were queried about the harmful practices, they identified several reasons. These included heavy caseloads, lack of standardized protocols for normal labor, poor communication, and a general lack of awareness of factors that contribute to maternal-infant death rates. In light of the increasing numbers of women seeking care in Egyptian hospitals, the findings from this study were concerning.

Based on the WHO classifications of normal birth, Sandin-Bojö, Hall-Lord, Axelsson, Uden, and Larsson (2003) led an exploratory study to develop an instrument to measure midwifery care practices in Sweden that supported NPB. A secondary aim of the study was to test the instrument for validity and inter-rater reliability. Using a Delphi method, six experts (four midwives and two obstetricians) from various geographical regions in Sweden joined together and developed a 78-item instrument. The instrument categorized care practices ranging from practices that were

demonstrably useful and should be encouraged to support normal birth to maternity care practices that were frequently used inappropriately. A Likert-like scale was administered to the six experts for judgment of content validity. Total consensus between panel members for inclusion of an item was achieved. Sandin Bojö et al. (2003) concluded, while content validity was achieved, the results of this study were exploratory only, and the feasibility of the study remains to be tested.

In response to the need for improved maternal-infant care, particularly in light of scarce resources, overuse of intervention and technology, and lack of evidence-based practices in developing and emerging post-communist countries, the European WHO organized a Perinatal Task Force in 1998 (WHO, 2002). The focus was to develop an instrument of measurement to provide guidelines and key indicators useful to evaluate the care for women who are candidates for normal birth (Chalmers & Porter, 2001). Starting with the WHO normal birth document (1996), the task force focused on developing a simple and objective tool to be used globally.

Using the most current evidence to support best practices associated with normal birth, including sensitivity to cultural issues, feasibility, and cost effectiveness, in 2000, the WHO Perinatal Task Force developed the Bologna Score (Chalmers & Porter, 2001). The goal of the Bologna Score was to identify the extent to which maternity care practices reflected birth the normal physiologic process of birth. The tool consisted of five quality indicators usually associated with NBP. They included the (s) presence of a companion at birth, (b) use of a partogram (labor graph), (c) absence of augmentation or emergency cesarean section, (d) use of a nonsupine

position for birth, and (e) skin-to-skin contact between mother and baby for at least 30 minutes within the first hour of birth.

A scoring system was developed, ranging from zero to five, with a score of five being the desired score. Zero was assigned if the quality indicator did not occur and a score of one was assigned if the indicator was part of the clinical management. The purpose of the Bologna score was to provide evidence of effective management of NPB as opposed to complicated or high-risk births. Chalmers and Porter (2001) reported on the group process that took place and published the instrument. Two studies used the Bologna Score to assess the effectiveness of maternity care.

Sandin-Bojö and Kvist (2008) studied maternity units across Sweden during a two-week period in 2007. In a prospective cross-sectional study, 51 Swedish maternity units were invited to participate in the study and 36 units agreed. The Bologna Score was used to measure evidence-based practice management. Findings revealed that Swedish intrapartum care varied from facility to facility. Maternity care and management based on current best evidence was practiced inconsistently. Of interest, the authors asserted that the wide variations in the Bologna Scores indicated that individual health care practitioners' attitudes and beliefs significantly influenced the maternity care provided to the woman. The researchers recommended the use of the Bologna Score as a quality indicator for assessing intrapartum care (Sandin-Bojö & Kvist).

A second study, conducted in Cambodia, used the Bologna Score to evaluate maternity care (Sandin-Bojö, Hashimoto, & Sugiura, 2011). The aftermath of the Khmer Rouge led genocide left the country of Cambodia with one of the highest rates

of maternal-infant morbidity and mortality in the world. As one of the least developed countries globally (Sandin-Bojö, et al., 2011), Cambodia recognized the need and importance of improving maternal-infant health. Sandin-Bojö and colleagues (2011), used the Bologna Score to examine childbirth practices at a tertiary care hospital, located in the largest city in Cambodia. Data was collected from 177 consecutive births. Midwives attended a majority of the births. Similar to the findings from the Swedish (Sandin-Bojö & Kvist, 2008) and Egyptian studies (Khalil et al. 2005), evidence-based care was not practiced in this tertiary care facility. Even though 69.5% of the women were identified as low risk on admission to the hospital, none of the births scored five points on the Bologna Score. The two common practices in the hospital that negatively affected the Bologna Score were women in a supine position for birth and the lack of a support person.

The Bologna Score, an instrument used for assessing care in normal labor and birth is recommended as a preferred evaluation tool in developing countries. (Sandin-Bojö et al., 2011). There is potential for this tool to become more widely accepted but more studies are needed to evaluate the usefulness and ease of use in birth settings around the world.

Lamaze Healthy Birth Practices

Romano and Lothian (2008) assert that the current western world paradigm of intervention-intensive care marginalizes the normal physiologic processes of birth. They maintain that the environment of technology in the current U.S. maternity system dominates nursing practice. The authors provide strong evidence to support the physiology of normal birth and the incorporation of the Lamaze six care practices into

labor care. Romano and Lothian (2008) argue that nurses are in a unique position to provide care that promotes and supports NPB.

The Lamaze Institute for Safe and Healthy Birth formally adopted the six evidence-based care practices that support normal birth in 2004. The six care practices represent decades of quality research and they include (a) allowing labor to begin on its own, (b) the freedom of movement throughout labor, (c) continuous labor support, (d) avoid the use of routine interventions, (e) spontaneous pushing in nonsupine positions, and (f) no separation of mother and baby after birth, with unlimited opportunities for breastfeeding (Lamaze International, 2004). Romano and Lothian (2008) provide evidence for each of the six care practices, and address the physiologic, psychological, social, and cultural aspects of the childbirth experience.

Zwelling (2008) concurred with Romano and Lothian (2008) by acknowledging the benefits of NPB for both mothers and newborns, but also identified the high-tech environment that intrapartum nurses currently practice in. Using the Lamaze six care practices (2004), Zwelling made eight recommendations that provide guidance for clinical nursing practice that allows for more of a balance between high-tech and NPB in the current climate of modern maternity care. The eight recommendations for nursing practice included an emphasis on awareness of evidence based practice, community involvement, reinstatement of prenatal education programs, the development of improved labor support skills, the support role of doulas, the advocating for institutional changes and participation in interdisciplinary committees. Perhaps one of the most important recommendations is for maternity care nurses to reflect on their own beliefs and philosophies about childbirth and examine how these

beliefs manifest themselves in everyday practice (Zwelling, 2008). Romano and Lothian (2008) and Zwelling make an important contribution to the literature by addressing NPB and nursing, and emphasize the challenges nurses face as they practice in the 21st century.

Intrapartum Nursing Maternity Care

While the evidence to support the benefits of NPB is strong, NPB hasn't consistently been addressed by the professionals who are most visible at the bedside of laboring women—the nurses. Nurses are the potential gatekeepers for care practices that reflect, support, protect, and promote NPB (Kennedy & Lyndon, 2008; Kennedy & Shannon, 2004; Romano & Lothian, 2008; Zwelling, 2008). Romano and Lothian, and Zwelling specifically addressed a gap in the literature regarding nursing care and NPB. Of the approximately 4 million births each year in the U.S., almost 99 percent of them occur in a hospital setting, and the remaining occur in a birth center or home (Boucher et al., 2009). Nurses are present at almost every birth in the U.S. and they are in a critically unique position to influence childbirth outcomes and maternal experiences (Carlton, Callister, Christiaens, & Walker, 2009; Edmonds & Jones, 2012; Kennedy & Lyndon; Romano & Lothian; Shah, 2006; Stark, 2008).

Carlton et al. (2009) confirmed that intrapartum nurses enjoy being part of women's lives during childbirth. Sleutel, Schultz, and Wyble (2007) found that nurses felt empowered and gratified when caring for women in labor and birth. Simpson (2003) states that, "labor room nurses love what they do and believe that their care makes a difference in outcomes for mothers and babies" (p. 766). However, Carlton et al. suggest that the intrapartum nurses' role is complex and there are many barriers to

best practices and supportive nursing care. The authors suggest that the complexities of the intrapartum nurses' role has been understudied. A high-touch, low-tech clinical practice environment, especially for nurses practicing in high-tech hospitals, may be unrealistic (Carlton et al.; James, Simpson, & Knox, 2003).

While benchmark data such as a physician's cesarean delivery rate is monitored and sometimes made public, there is some literature to support that a nurse's cesarean delivery rate should be monitored and published as well (Hodnett, 1996; Hodnett, Gates, Hofmeyr, & Sakala, 2007; Hodnett et al., 2002; Regan & Liaschenko, 2009). Regan and Liaschenko examined intrapartum nurses' cognitive frames (thought processes) of childbirth, especially in relation to cesarean delivery. They found that nurses tend to frame childbirth in one of three ways: birth as a normal process, birth as a lurking risk or birth as risky process. The authors reported that the framework for which a nurse views birth leads to certain behaviors and actions, and can affect birth outcomes, especially as it related to use of medical intervention(s) and cesarean delivery.

Goldberg (2002) believes that the medicalization of birth has led to a "dehumanization of the birthing experience" (p. 446), heavily influenced by the Cartesian duality of scientific thought- the separation of mind and body. The author believes this view has permeated (intrapartum) nursing practice and reduced nursing care to mostly technology driven tasks, caring for women as if they are physical objects or machines.

Most recently in the literature, Edmonds and Jones (2013) examined intrapartum nurses' perceived influence on maternal outcomes, especially cesarean

delivery. These two authors focused only on settings where labors were nurse-managed or on labor units where the nurses had increased autonomy. The nurses made many of the decisions while the physicians were off site during labor. Nurse-managed settings are the predominant model in the U.S. These settings are different than physician-led units where medical residents, fellows, and attending physicians are physically present on the unit at all times, making many of the decisions, and directing the nursing care (Edmonds & Jones, 2013). Edmonds and Jones revealed that nurses needed more time to practice and to promote vaginal birth. All of the nurses in this study believed they were experts in the care of women in labor and birth. However, the nurses found themselves consistently negotiating for more time and for less medical intervention in order to achieve safe maternal outcomes.

Sleutel, Schultz, and Wyble (2007) explored labor and delivery nurses' views of intrapartum nursing care. Findings included a spectrum of views, ranging from intense pride for caring for women in labor and birth to disillusionment and distress based on barriers to provide optimal nursing care. Participants in this study revealed that medical interventions were a consistent barrier to providing labor support.

Barrett and Stark (2009) explored barriers to the practice of labor support by intrapartum nurses, with a specific focus on institutional factors. Findings suggest that the birth environment may influence the care that intrapartum nurses are able to practice. The authors suggest that a birth environment that supports normal birth may be the best place for supportive nursing care in labor and birth.

Intrapartum nurses have the primary responsibility to balance the needs of the childbearing family while managing the challenges of maternal/fetal surveillance. This

is a demanding and complex role in today's culture of birth (Downe et al., 2007; Edmonds & Jones, 2012; Hodnett, 1996; Zwelling, 2008). The constantly changing census of patients, the changing demographics of childbearing women, and the medically litigious environment of health care are only a few of the factors that have an influence on the nursing care. Nurses find themselves consumed with practicing continuous EFM, overseeing the increasing number of labor inductions and/or managing the adverse side effects of epidural anesthesia (Hodnett et al., 2007; Simpson, 2003). Nurses are being drawn away from supportive care of women in labor and have become preoccupied with the management of technology (Hodnett et al., 2007; Payant et al., 2008; Zwelling, 2008).

Currently, there is limited research that specifically focuses on nurses' perceptions about NPB, and the barriers and facilitators for nursing practices that support and promote NPB in the medically dominated paradigm of maternity care in the U.S. Future research in this area, specifically focusing on nursing practice and NPB is needed.

Conclusion

The majority of women in the world are healthy and at low risk for complications during pregnancy and birth. The research reviewed in this body of work suggests that a major paradigm shift from the prevailing worldview of childbirth as a high-risk event is needed. Regan and Liaschenko (2007) explored how viewing birth as a "lurking risk" predisposes women to higher rates of medical intervention(s) and cesarean delivery. Unnecessary use of technology and routine intervention(s) dominate the current maternity system. In the last two decades, there has been an acceleration of

the use of interventive practices to initiate, augment, regulate, and monitor women in labor (Declercq, et al., 2013). The use of routine regional anesthetic, restriction of women's movement, withholding of nourishment in labor, continuous EFM, rising cesarean delivery rates, and vacuum extractor and forceps for delivery have all led to a subtle but powerful belief that women can't give birth unless they are tethered to machinery and assisted by medical intervention (Davis-Floyd as cited in Downe, 2008; Downe, 2008). Collectively, the adherence to labor graphs, busy health care providers schedules, fear of litigation, the economics and culture of the organization, and individual beliefs all play a significant role in birth outcomes in the U.S. maternity health care system. Outcomes such as maternal and infant mortality rates fail to reflect the vast amount of resources required in a technology-managed birth in the current U.S. system (Althabe & Belizan, 2006; Declercq, et al., 2013; Ehrenthal, Jiang, & Strobino, 2010; MacDorman, et al., 2006).

In 1996, WHO responded to the rising maternal-infant mortality rates worldwide, especially in developing countries. As a consequence, a working definition of normal birth was adopted, and provided strong evidence to support normal birth throughout the world (WHO). Several policy statements, definitions, and concept analyses have emerged over the last decade based on the WHO document (the Consensus Statement by ACNM, MANA, and NACPM, 2012; the Canadian Consensus Statement, 2008; The MCWP, 2007). There is wide variety in the definitions of normal birth around the world.

In conclusion, The Institute of Medicine's report *The Future of Nursing: Leading Change, Advancing Health* (2010) recommends that nurses, as frontline care

providers of patient care have the unique opportunity to understand what works well and where improvements are needed. This positions nurses to be potential leaders in the reshaping and improvement of health care system in the U.S. This recommendation provides a foundation for the argument that nurses are present at almost every birth that takes place in the U.S., they therefore have a unique opportunity to be leaders in the maternity care setting and can set the example by providing care to women in labor and birth based on the best available evidence. In doing so, nurses can promote and support maternity care that creates a better and safer place for our mothers and babies.

Chapter III

Methodology

Qualitative Research Methods

Qualitative research has its roots in the social sciences of sociology and anthropology. Using a variety of approaches, it is generally a loosely structured non-experimental research method, involving a relationship between the researcher and the respondent. It can involve rich description, personal narratives or meaning making of the lived experience of an individual or group of individuals. It is grounded in a relativistic ontology and is contrary to positivist paradigm (Lincoln & Guba, 1985). Polit and Beck (2012) suggest that qualitative research is time consuming and the data can be challenging to analyze. Historically, qualitative research has been disputed by modern science, which has been slow and sometimes reluctant to consider qualitative research as legitimate and transferable (Downe, 2008). Sandelowski (2000) asserts that qualitative methods in nursing and other health sciences are emerging as effective research methods when descriptions of phenomena are sought-after.

Purpose and Research Design

The purpose of this descriptive, qualitative study was to explore intrapartum nurses' beliefs about childbirth. Its specific aim was to identify and describe the nature of intrapartum nurses' beliefs, and how these beliefs affected the way in which the nurses provide nursing care, and what factors influenced their clinical practice. Nurses' perceptions about NPB and factors that promote and support NPB practices were also explored.

A considerable body of research recognizes intrapartum nurses unique position to influence and affect the care and outcomes for women and newborns in labor and birth. However, despite the fact that nurses provide the majority of direct clinical care for women in labor and birth in the hospital setting, there is a paucity of research on nurses' beliefs about childbirth, their perceptions of NPB and factors that support or hinder clinical nursing practices that promote NPB.

A qualitative inductive approach was used for this study. Semi-structured, in-depth interviews were conducted with 10 intrapartum registered nurses (RN). A qualitative design was chosen to describe the perspectives of the study participants. The study was designed to address the following research questions:

1. What is the nature of intrapartum nurses' underlying beliefs about labor and birth?
2. How were these beliefs initially formed and did they evolve over time? If so how?
3. To what extent do intrapartum nurses' think that their beliefs affect the way in which they provide care to women in labor and birth, and what factors influence this?
4. What do intrapartum nurses perceive about normal physiologic birth and what are the barriers and facilitators for nursing practices that support and promote normal physiologic birth?

Rubin and Rubin's (2012) model of qualitative interviewing was used to guide data collection. This method allows for a bi-directional conversation with participants whereby the researcher can solicit in-depth information on complex issues, probing for

a further response, and clarification when needed. Participants are able to provide in-depth information in their own words on a topic that has attracted little or no research to date.

The researcher conducted the interviews using the responsive interview model (Rubin & Rubin, 2012), seeking in-depth responses that reflect the perspectives and experiences of the participants. Flexible questions evolved from what the participants shared. The tone of the questioning was friendly and non-confrontational. The method of interviewing was emphasized as a process of conversational partnership (Rubin & Rubin), and the researcher and participant equally took active roles in the discussion. Immediately prior to the start of the interview, the interviewer tried to make clear to the participants that the researcher recognized them as trusted and reliable experts. Although interviews were guided by a number of key open-ended questions, not all questions were asked of every participant, as the questions were intended to guide the conversation, rather than prescribe it. The researcher experienced an unexpected challenge in conducting the interviews. The first three participants attempted to use the interview to share work and personnel related issues from their clinical unit. This experience prepared the researcher for all the subsequent interviews. When a participant began to discuss work and personnel issues, the researcher gently guided the participant back to the research topics. The interview guide (Appendix A) was a particularly useful tool in this process.

Participants

Ten female, Caucasian intrapartum registered nurses (RN), ranging in age from 38 to 62 years of age participated in the study. All of the participants were experienced

intrapartum nurses (12 to 39 years of experience). Eight of the 10 participants held a bachelor's degree in nursing. All of the participants were employed at a level III hospital for women and newborns in the Northeast region of the U.S. This facility is considered one of the nation's leading specialty hospitals for maternity care. It is the eighth largest stand-alone obstetrical hospital in the country with over 8,400 deliveries per year. This setting was chosen because of the limited amount of research available regarding intrapartum nursing practice in the academic, tertiary maternity care setting. The 2012 cesarean delivery rate at this hospital was approximately 35% (Rhode Island Department of Health).

A sample of ten participants was selected based on Strauss and Corbin's (1998) argument that at least ten participants are necessary to identify emergent patterns and themes to reach saturation of data. A snowball sampling technique was utilized to recruit the ten participants. The researcher identified the first two eligible study participants by word of mouth. Recruitment continued on the basis of participant referrals thereafter. Snowball sampling, also known as chain sampling can be a dynamic method of recruitment. Inherent to the process of referrals from other participants, the benefits of snowball sampling can create a unique social knowledge undergirding the interaction between the researcher and interviewee (Noy, 2008). Snowball sampling has disadvantages as well. It is not a random sample, and the first few participants may have a significant impact on the sample. The possibility that the sample does not represent the targeted population is another disadvantage that researchers must acknowledge (Sadler, Lee, Lim, & Fullerton, 2010).

The screening process took place by email, in-person or by telephone during the initial point of contact with the potentially eligible RN. Once there was an expressed interest to participate in the study, a recruitment letter was sent to the participant by email (Appendix B), along with the informed consent (Appendix C). As part of the email communication participants were asked to read the informed consent, print it out, and bring an unsigned copy to the interview for signature. A small compensation was given to the participants for their time and travel.

The study interviews took place between August and October 2013, in a private space, in a location outside of the hospital that was mutually convenient for both study participant and researcher, in order to ensure participant confidentiality and privacy. The first two participants picked the location of the interview. The first interview took place in a small café in an urban setting, and the second interview took place at large chain restaurant, in the suburbs. While both settings were comfortable and conducive to discussion; the background noise was a challenge for the audio recording. To address this challenge, the locations for the following interviews were determined by the researcher and took place in a small, quiet conference room, in a building nearby but separate from the main hospital where participants practiced. The environment was comfortable, quiet, and convenient for participants. All of the interviews lasted between 1-1/2 and 2 hours.

The purpose of the research study was explained to all of the participants individually, along with any potential risks and benefits. The study was composed of two parts. The first was the completion of a demographic questionnaire (Appendix E) and the second part was a semi-structured interview. At the start of the study interview,

all participants provided written informed consent (Appendix C) and agreed to be interviewed and audio recorded. Contact information was documented on a study-specific contact sheet (Appendix D). All participants had the opportunity to ask questions prior to signing the informed consent form. All participants received a copy of the signed informed consent. Once both the participant and the researcher signed the consent form, the interview commenced. In order to ensure the accuracy of the participants' responses, interviews were audio recorded using a Sony ICD-UX71 digital recording device. The recordings were saved on the researcher's password protected and encrypted personal computer. The researcher was responsible for ensuring that the computer was securely stored away in a locked drawer in her a personal office when not in use

At the beginning of the interview, the participants were asked to complete a personal information sheet. They were asked to provide their residence address, email address, and contact telephone numbers (Appendix D). A self-administered questionnaire to obtain demographic information was also given to the participants (Appendix E).

Individual semi-structured interviews using Rubin and Rubin's (2012) responsive interview model were used along with a qualitative interview guide. The content of the interview guide (Appendix A) was informed by the research questions and consisted of open-ended primary questions, complimented with a series of additional probing questions or prompts to clarify responses and follow-up on points of interest.

The interview guide (Appendix A) consisted of the following topics: background for becoming an intrapartum nurse; beliefs about labor and birth; perceptions about nursing practice in the labor and delivery setting, and factors that influence practice; and perceptions about NPB within the context of Lamaze International's six clinical care practices.

The first question in the interview guide focused specifically on the participants experience as a labor and delivery nurse. For example, questions about factors that led them to intrapartum nursing care and if they enjoyed practicing as a labor and delivery nurse was used as probes. The participants were very willing to describe what kinds of experiences led them to intrapartum nursing, and what aspects of the practice they liked and disliked. The second question, "What are your beliefs about labor and birth" was more challenging. The first three participants had difficulty answering this question. After the researcher recognized this, the direct questioning regarding beliefs was avoided. Instead, the participants were asked to describe a typical birth experience that they most enjoyed being part of or to describe their best birth story. This method revealed rich narratives and storytelling. This less direct method revealed beliefs about childbirth and intrapartum nursing practices that were most compelling to the participants.

The third question in the interview guide, "How do you think your beliefs about labor and birth influence the way you practice nursing and provide care for women in labor and birth" also seemed too direct. Once again, this information was obtained through narrative and storytelling about best birth scenarios. Also helpful for this question were probes emphasizing the specific ways in which the participant

provided nursing care in specific situations, i.e. induction of labor, women wanting to experience NPB and issues around epidural anesthesia.

The fourth and fifth questions were combined to discuss the specifics about the barriers and facilitators to Lamaze International's Six Care Practices that support and promote NPB. A copy of Roman and Lothian's (2008) article emphasizing the six care practices in relation to nursing care was provided at this point in the interview.

Discussing this question seemed easier for the participants as it was more concrete.

Data Analysis

Rubin and Rubin (2012) maintain that the process of analysis is strengthened by the richness, thoroughness, and nuances that are built into the research design. The authors suggested a series of steps to follow in order to assist the researcher to accurately identify concepts and interpret the meaning of the data to provide clear and compelling answers to the research questions.

The researcher took some notes during the interview, but relied on the audio recording for the most in-depth understanding of data. After each interview, the researcher listened to the interview within 24 hours in order to get a sense of the whole dialogue. Notes were also taken at this time. Once the audio recording was listened to, the recording was converted into an audio file and was sent by email to a transcription service in another state. The file was transcribed into a readable narrative format (word document) and sent back to the researcher usually within 3 to 4 days. A member of a non-profit academic research institute recommended the transcription service as a reliable and confidential service. The transcription service considered the sensitivity of the confidentiality information as one of the most important aspects of its work. Any

participant identification was removed prior to transcription. Once the transcription was emailed back to the researcher, it was uploaded into a qualitative data analysis software program known as Atlas. ti 6.2. The researcher then systematically coded the data, which allowed for the generation of categories and themes to address the four research questions.

Once the raw data from the interviews was collected, listened to, transcribed, and carefully summarized, the researcher began the process of coding, or labeling the concepts, categories/themes, and examples in the transcripts. Initially, the data was color-coded and organized by research questions, to identify emerging categories and themes. Each research question category had sub-codes (See Table 1). Multiple memos were written into the text and 19 separate codes were identified as specific units of analysis. The same codes were then placed together in a single file. Sorting and resorting within each file led to the identification of subgroups, which were also individually coded. After the process of coding was complete, the researcher decided on the final categories of the data and identified the overarching concepts and themes. Specific quotes were chosen that the researcher perceived as most representative of the emerging categories and themes. Once this step was completed, the researcher examined if and how the concepts were related. Discussions and meetings between the researcher, and the first two dissertation committee members who are experts in the content and qualitative methodology allowed for further connections to be made between the research question and findings from the data.

Table 1

Categories and Sub-categories used for coding

Research Question 1	Research Question 2	Research Question 3	Research Question 4	Best Birth Scenarios
Underlying Beliefs	Formation of beliefs and changes over time	Beliefs affect practice and influencing factors	NPB/Barriers/ Facilitators	
Birth is powerful event	Personal birth experience	Organizational influence	Barriers to promoting and supporting NPB	
Birth according to patient		Technology/electronic	Facilitators to promoting and supporting NPB	
Power of nurses voice		Today's generation of women	Perception of NPB	
		Relationship with provider	Six Care Practices	
		Patient physician relationship		
		Subtle defiance		

Ethical Issues and Efforts at Enhancing Credibility

Approval to conduct this study was obtained from the University of Rhode Island Institutional Review Boards (Appendix F). Participant confidentiality was

maintained throughout the study. Identification numbers one through ten were assigned to each participant. Transcription, coding and analysis were completed using the participant's identification number only.

In qualitative research, establishing trustworthiness and integrity is measured using criteria involving how well the researcher provides evidence that the analysis accurately represents the perspectives of the participants in relation to the phenomenon being studied. In this study, a number of steps, based on criteria developed by Rubin and Rubin (2012) and Lincoln and Guba (1985) were used to enhance the accuracy and credibility of the research.

Rubin and Rubin (2012) assert that the credibility of qualitative research relies on how well informed the participants are regarding the research problem. The study participants were RNs working at an institution with a very high volume of births. Participants were "encultured informants" (p. 65), individuals who know the culture of labor and birth on this particular unit, and were willing to share their experiences and perceptions with the researcher. Miles and Huberman (1994) suggest that the researcher's expertise and experience in the field also increases credibility. The researcher was a certified nurse-midwife with 23 years of professional experience and an assistant professor at a local school of nursing in the maternity and newborn specialty.

Credibility was enhanced by reflective journaling and an emphasis on transparency throughout the research and analysis process. To support the trustworthiness of the study findings, the researcher documented how the data were obtained, recorded and analyzed. She also established an audit trail of the data

collection and analysis (Rubin & Rubin, 2012). Detailed notes were kept during and after the completed interviews.

Member checking provides the researcher the opportunity to check with the participant to confirm the understanding of what was being said. For this research study, member checks outside of the interviews were unnecessary. The researcher used the process of member checking throughout the interview by paraphrasing and rephrasing what she thought was said. If there was something said that was unclear, or misunderstood, the researcher paused and verbally checked with the participants for clarification. Also, throughout the interviews, approximately every 30 minutes, the researcher would provide summarization for what she believed she had heard. Using an audit trail to document the process of data collection and analysis, the researcher noted and marked many excerpts generated during the coding process. This served as a record to assess the development of the study findings. In order to process the vast amounts of information obtained throughout the data collection process, and to evaluate whether or not the interpretations, findings and conclusions were supported by the data, an ongoing debriefing with external audits (three experienced qualitative researchers, including the committee chair) was conducted throughout the research and analysis process.

Transferability was enhanced through description of rich, authentic, and impressive quotes. The participants' told their stories with generous description, reflection, and vividness. The researcher tried to reflect the participant's stories as accurately as possible.

In order to enhance trustworthiness, the transparency of the researcher's predispositions and underlying beliefs on the topic were openly revealed. Participants knew the researcher as both an experienced nurse-midwife and nurse educator. All of the participants seemed comfortable engaging in open and honest conversation. Once credibility and transparency were established, the researcher was confident that transferability was enhanced.

Qualitative research, as a process of naturalistic inquiry offers a rich and comprehensive method of data collection. In this research study, ten participants offered detailed and complex descriptions of their beliefs, perceptions and experiences as intrapartum nurses in a tertiary care maternity hospital setting. Five underlying beliefs about childbirth emerged. Factors that influence the way in which nurses' provide care to women in labor and birth were also described. The following chapter is a description of findings with discussion to follow.

Chapter IV

Findings and Discussion

The purpose of this study was to explore intrapartum nurses' beliefs about childbirth. Its specific aim was to identify and describe the nature of intrapartum nurses' beliefs, how these beliefs affect the way in which they provide nursing care, and what factors influence their clinical practice. Nurses' perceptions about NPB and factors that support and hinder NPB practices will also be discussed.

The results of this study were based on in-depth interviews with ten intrapartum RNs currently practicing in an urban tertiary care maternity hospital. Research findings and analysis will be presented in relation to four of the study's research questions. The four research questions are:

1. What is the nature of intrapartum nurses' underlying beliefs about labor and birth?
2. How were these beliefs initially formed and did they evolve over time? If so, how?
3. To what extent do intrapartum nurses think that their beliefs affect the way in which they provide care to women in labor and birth and what factors influence this?
4. What do intrapartum nurses perceive about NPB and what are the barriers and facilitators for nursing practices that promote, support and protect NPB?

Discussion of the results will follow the description of the research findings.

Language and Terms Used in Interviews

As addressed in the literature review, the definition of NPB varies. There is also variation in the language an individual uses when describing NPB. The participants in this study referred to NPB as “going natural,” “natural birth,” “normal birth,” “doing it on your own,” and “delivering without anesthesia.” None of the participants in this study referred to NPB as “normal physiologic birth.” My understanding of the language used in maternity nursing, especially on this particular unit, enabled me to recognize when participants were talking about a type of birth that indicates NPB, or an interventive, medicalized birth. For the vast majority of time when participants referred to pregnant and laboring women they used the term “patient.” Other terms used interchangeably for women in labor and birth were “people,” “woman” or “women,” or “laboring women.”

Findings

Research Question One: *What is the nature of intrapartum nurses underlying beliefs about labor and birth?*

Using Rubin and Rubin’s (2012) conversational partnerships model, nuanced responsive interviewing techniques, and best birth storytelling, five core beliefs about childbirth emerged. The beliefs are (a) childbirth is a profound and empowering event in a woman’s life, (b) providing care to women during childbirth is rewarding, (c) women should be supported in their choice for the type of birth that they believe is right for them, (d) women’s satisfaction with the birth experience is important, and (e) intrapartum nurses are experts in the care of women in labor and birth. The following

section includes discussion and excerpts highlighting each of the participant's five beliefs.

Childbirth is a profound and empowering event in a woman's life. All of the participants in the study believed that childbirth was a significant event in a woman's life. The majority of nurses believed it was a life-changing experience that most women will remember forever. For example, a participant said:

. . . so I believe it's (birth) sacred. I think it's a once in a lifetime experience -- once, or twice, or three times, not very many -- you don't have that experience many times in your life, so it's a huge -- it's a life changing event. It can be spiritual. It can bond families. It can really have an impact on the relationship of the parents. I think it's -- it is natural, it should be left alone. We shouldn't have to intervene as much as we do. And I think it should be respected.

Emphasizing the belief that a woman's birth is a memorable lifetime experience, another participant remarked:

I think that it's a very spiritual experience, having a baby, and that experience is life-long. You can ask an 80-year-old woman what her birth experience was like, and she can tell you in very great detail, usually.

Almost half of the participants used words like "empower" and "power" to describe how laboring women felt after a positive birth experience. For instance, a participant remarked that she believed women were empowered by a positive birth experience, *"for me, I think a great birth is a woman feeling empowered, and a family*

feeling connected because of this experience.” Several participants alluded to the belief that this empowerment potentially gave women the strength to navigate difficult experiences later on in life and contributed positively to the new family. Two participants stated it this way:

. . . the powerfulness of saying to her, ‘Oh you did it.’ I just wanted to like grab her, I felt like her great birth experience empowered her and I was there to be part of her experience, as a bystander in her hour. And I said, “I hope you know that no matter in life what you have to tackle, that if you can do this you can do anything. That’s what I think about you.” You’re empowering her in that way too. Not going to shame her now that she’s got the epidural. You want to empower her that she’s going to give birth. She’s doing it the right way herself.

Providing care to women during childbirth is rewarding. Participants also discussed the personal satisfaction experienced from being able to be part of this special event in a woman’s life:

I mean, how can you have a better connection with a human being during that time (birth)? And to get her through that time -- I mean, it’s a personal satisfaction. It’s a personal satisfaction in the sense that you are able to help someone get through something that was so difficult.

A second participant stated:

Because I think it’s (birth) one of the most intimate things you can share with a human being. And I really think you can affect change, affect the outcome with your nursing care.

When asked to describe their most memorable birth scenarios, a couple of participants linked the importance of the event in a woman's life to a personal satisfaction supporting a professional pride.

I think having a baby is one of the best things in the world. It's the power of the woman. Being able to give birth is an absolutely amazing, powerful feat. And having taken care of friends who have had babies that are now in their twenties, you know, and they'll still talk about their births with me, and that's always nice.

Women should be supported in their choice for the type of birth that they believe is right for them. All participants emphasized the importance of supporting women's choices for the type of birth or experience that they had chosen or for which they planned. For example, one participant described the ideal birth scenario as a process that was defined by the woman:

That's the best part of the day. A happy, healthy mom and a happy, healthy baby, no matter which way it got here, but according to mom's plan.

Similarly, another participant said:

I want her to feel proud of herself. I want her to feel empowered to be able to give birth to her baby. I want her to feel very good about her experience when she's through, and looks back. I want her just to think that it was a positive experience.

All of the participants believed that whether a woman wanted to have a natural childbirth or a medically interventive birth, it was her choice, and she should be

supported either way. When asked specifically about supporting women for a NPB, repeatedly again I heard, *“It depends on what she wants or how she wants her birth to go,”* or *“really, it is up to her.”* One participant stated:

But my belief too is -- I love that (referring to NPB) but I also believe that they (women in labor and birth) should have that choice. They should be the one making the decision about this...

A second participant stated:

I mean, I don't think everyone should be forced to have a natural childbirth. It should be the choice of the patient. I think if I ever had children, I eventually would have an epidural. I would hope I wouldn't have one at two centimeters though. But in the end it is the patient's choice...

A third participant further emphasized the importance of women's choice in birth:

And I will help her with whatever she chooses but I'm not going to be a pusher in any direction. But I think the key is to -- to talk to the patient, to listen to them, and take the cues from them.

The majority of participants also believed that more and more women were presenting to the labor and birth unit with little or no knowledge about the process of birth. Given the consistent belief by all of the participants that women should choose their own birth plan, this issue presented challenges. One participant stated, *“I mean, they (some women) don't even understand the physiology of being pregnant, or labor, or anything like that.”* Another participant discussed the challenges of working with a

woman in labor when not only was she unprepared for birth but also was perceived as “not caring.”

But it’s hard, it’s really hard for me when I get patients who just don’t really care, or don’t have a plan, or . . . You know, the ones that come in texting. And it’s just like, “OK, yeah, I’ll get my epidural.” And, “Yeah, oh, it’s time to push.” “OK.” And then, the baby, skin-to-skin -- “Well, that’s just my nightmare.

While recognizing the importance of the role of the nurse as patient educator, the following participant maintained that meeting a woman for the first time when she was admitted or in active labor was not the ideal time to start the education process:

Well, it seems like it’s mostly left up to us to do that kind of education (speaking about educating women about options for birth). And I think it would be helpful if it got started before they actually hit the labor room. I mean, depending upon how long you have with the patient, (laughter) they can kind of come to terms with, or absorb some of this information. But I think as human beings -- it takes a while. And if you don’t have a chance to talk to your family, your friends, your husband, about some of these choices, or take classes. I mean, it’s a lot, once you hit a labor room, to deal with all that. So -- but I -- we are teachers. Labor- room nurses have a fantastic opportunity to teach. I love that part of it, but it can be such a challenge if you are starting from ground zero when they are admitted.

Women's satisfaction with the birth experience is important. The majority of participants attributed great value to the new mother's level of satisfaction with her birthing experience. At least half of the participants maintained that when a new mother considered that her birth went according to her plan and/or she felt well cared for, her satisfaction was directly linked with the quality of nursing care she received. Patient satisfaction was often described as an expression of gratitude from the patient. For example, a participant stated:

I just like the whole experience. And I hope that what I do makes -- gives people a good impression of their birth because most of the time it's happy and they're grateful, very grateful for what I do.

When asked about some of her most memorable birth experiences, one participant described a birth where the care she provided was not only deeply satisfying for her, but to the patient as well:

OK, well, I can remember one that was a cesarean. I had a woman who had a rough life--she had been a drug addict and everything, and she really cleaned up her life. And she had a lot of anxiety about birth... She had a great partner who was supporting her and was doing everything to help her through her birth. She labored for a while, she got an epidural and she was so nervous. Unfortunately her labor didn't progress, and she needed a C-section. And I know that she was really anxious about being separated from the baby. So luckily I was her nurse that whole day, for 12 hours, and she went to the operating room, and we had a gentle cesarean and it wasn't what she wanted, but she adjusted to it.

She was so thankful to me because she was able to have the baby right away, and I knew how important it was for her. She kept on telling me how she wanted the baby to come on her skin to skin right away. So that -- I mean, I'll always remember her. That was a great birth.

When asked what made this birth so great, the participant explained: I think she (the patient) was relieved that she got to be with the baby right away, even though it didn't go how she had planned. She was elated because she had done so much in her life to be able to actually parent this child. She had cleaned up her life and done so many things, and she had a picture in her mind of what the birth would look like, but it didn't go like that, and she adjusted to it.

Another participant also discussed patient satisfaction in terms of whether or not the woman's birth went according to her plan:

For me, I think a great birth is a woman feeling empowered, and a family feeling connected because of the experience. I think a family being respected, being talked to, being made part of the plan. And then honoring the things that they want, if they have expressed things to me that are important to them, if they have a birth plan, or if they've said, oh, this is what I want to happen at my birth, if we've been able to do those things as much as we can, I think that's a great birth.

Intrapartum nurses are experts in the care of women in labor and birth.

Many of the participants expressed the belief that when a laboring woman listened to their suggestions and accepted their guidance, nursing care had the potential to

positively influence the birth experience. The following participant emphasized the importance of intrapartum nurses being informative and assisting with decision-making in the process of birth:

I think just by working with our patients, and kind of helping them interpret the reality of the situation, our role is influential. We very often help them make decisions by informing them about their options, and explaining to them what is happening. “Do I want my epidural now? Do I want to walk for a little bit?” All of that kind of stuff.

A second participant explained:

. . . And I really feel I can make an impact on how she (woman in birth) views herself as a mother, as a woman, for her entire life.

The following participant described labor as a collaborative experience between the nurse and the women alluding to the importance of her knowledge and skills:

And then I’ll say, ‘you and I are going to go through this process together. I’m not going to leave you in here on your own to decide what pain is too much pain. If you’re interested in an epidural we’re going to assess that from minute to minute and then we will come together to decide when that’s the appropriate time. So you don’t have to ask me right now when you should get an epidural, because we’re going to be in this together. And I’ll help you to know when that is. We don’t want it too late. We don’t want it too early. We’ll get there together.

A third participant associated her level of expertise and sense of professional confidence with the number of years she has been practicing.

I feel like there's more that I know now. I feel like I have more impact now. And I don't know if it's because I have more experience and I'm not nervous anymore, like, I really feel like I have the knowledge, I know what's best for a family welcoming a newborn. I feel like there's things that are so important that they might not even know about, so I kind of -- I don't want to say I have my own agenda, but I read about it all the time, I research it, I've worked in it. I know this stuff.

Many participants also stressed the importance of patient safety. For example, one participant discussed the role that nurses play in establishing what is reasonable and safe during labor:

You know... I think you have to look at the person and see what their expectations are, and try to guide them to what you believe is reasonable. I think patients need to be aware that complications can arise, like if a woman's water breaks and she has meconium, we have to be able to redirect what's going to happen at the birth that wouldn't happen if we didn't have that. I do think you have to go by what people want, and let them have the birth that they want but within safe means.

A second participant discussed the importance of patient choice as well, but also emphasized that the establishment of safety is a big part of the plan:

I've done deliveries in the ABC, I've done deliveries with epidurals, without epidurals, with doctors, with midwives, with doulas, without

doulas, with the patient all by herself, with the patient with several family members. I'm willing to do a delivery however the patient wants it provided the patient and the baby is safe. When safety's involved, safety overrules.

In summary, the responses to research question number one provide a foundation for what intrapartum nurses in this setting believed about childbirth. Recognizing birth as a significant event in a woman's life, the majority of participants emphasized that a favorable labor and birth experience positively influenced the new mother, the new family and the attending intrapartum nurse as well. All of the participants believed that women's birth plan should be supported; however, the limited level of a woman's preparedness for birth can challenge this. The majority of nurses believed that they are experts in the care of women in labor and birth. They believed that their role as intrapartum nurses involves establishing safety for mother and fetus, and educating women to the advantages and disadvantages of their choices and birth plan. While all participants considered themselves as experts in the care of women in labor and birth, many factors were identified which influence expert nursing care at the bedside of laboring women. These factors will be described in research question number three.

Research Question Two: *How were these beliefs initially formed? Did they evolve over time? If so, how?*

The aim of this research question was to obtain a deeper understanding of the origins of the participant's beliefs as they entered nursing practice, and how they evolved over time. At least half of the participants were drawn to intrapartum nursing

because of their personal experience with childbirth. Three participants came to this type of nursing specialty through employment and/or staffing needs. Two participants were drawn to this specialty as a result of their positive clinical experience in nursing school. The majority of participants readily explained the path they took to become a practicing intrapartum nurse, but what they believed about childbirth prior to this was not well articulated.

Personal experience. Half of the participants were drawn to intrapartum nursing because they recognized the significance of childbirth in a woman's life, either in their own life or in the life of a family member. One participant spoke about her own wonderful birth experience, which led her toward a desire to be part of other women's birth experiences.

It was a wonderful experience. And I had a lay midwife who attended the birth. And I decided that I would love to be a part of that whole experience. It was one of those moments where it's -- just like if -- I felt like she had a therapeutic touch, and I felt, "Boy, if I could do that for women in this world, that would really give me a lot of pleasure."

When asked if her own birth experience provided a foundation for what she does now, she replied:

I'm feeling that I'm really doing what I set out to do, which is to help families have as good a birth experience as possible.

Another participant also revealed that her own birth experience was instrumental to becoming an intrapartum nurse:

And so my labor was a prolonged latent phase, typical first baby stuff (meaning it was long and difficult right from the start). The nurse was great, and when she left the room at one point I turned to (my husband) and I said, “This is what I want to do, I want to do what she’s doing.” So that’s how I came here.

A third participant also described how her beliefs and practice evolved. She had a very difficult labor, which ended in a cesarean. She talked about how scared she was, and she believed that she was traumatized by the experience. She recognized how ‘scary ‘ it can be for some women, and she takes extra steps to be reassuring:

It was just so scary, it was really traumatic. And now, we do see some of these very young women come in, and you know, it’s like they are scared to death. So, when I go into the operating room, I always take extra care to go over and make sure that they’re... someone is talking to them. Reassuring them and talking because they take the husband away, they are in a new room, the anesthesiologist is there, they are busy doing their stuff, and the poor patients’ like, scared to death.

She went on to say:

I ended up having a premature baby and I never had skin-to-skin (baby placed on her chest). I would have loved my baby with me. So now, I always promote skin-to-skin, because I know how important it is. And then, when they want the (newborn) weight, I usually bring the scale right by the bed; pop it (baby) on. Then they can see it. So it’s nicer.

A fourth participant also spoke about how her beliefs and practice evolved from personal experience. After describing her first birth, which was difficult, she was asked if she thought this experience had changed her practice:

Absolutely. It has hugely impacted my nursing practice. I had not only had a difficult time with my birth, but I had severe postpartum depression, and that changed me a lot as a practitioner and a person. And I really, I bring that with me. I carry it around every day, and I bring it into my practice. And I really try to key into people who may have those issues, especially if there is a history of depression. I talk to them when they are giving me their history and I say to the husband, “you got to make sure you keep an eye on her.”

Employment opportunity. Three other participants got into intrapartum nursing because of staffing changes on other units or the availability of a position on labor and delivery. A couple of participants ended up in intrapartum nursing solely because of the availability of a position:

I was a NICU nurse and I wanted to change my hours so I came here temporarily 27 years ago. But I never left. I think I just got comfortable. I think with most of my colleagues I have a sense of camaraderie. So I think that’s what made me stay. I also think the patients in labor and delivery appreciate their nurses a lot, and I think that’s a big part of it. What’s interesting about this participant is that when asked:

If you're taking care of a midwifery patient that is low-risk, and they want to have intermittent monitoring, are you completely comfortable with that? (Researcher)

She replied:

Sometimes I'm not comfortable (with intermittent monitoring), but I try to do the best I can. I think -- maybe from my NICU days, I just like to see what's going on.

This participant made a connection with her past experience in a high tech environment to her practice now in the labor and birthing unit, even with low-risk women. A second participant ended up in intrapartum nursing because of a float pool assignment. She also had come from the NICU setting:

I was in the float pool, so I worked on the postpartum unit, on Med-Surg, a little bit in the NICU. I then switched to days after a year, and then I got to see a little bit more of the PACU, and NICU, and a little bit of ED, but I always liked the baby units and knew that at some point I wanted to head down to the labor room. And so after two years -- I did a year on nights, a year on days, and then I went to the labor room. I've been in the labor room for 14 and a half years, and I love it. It's different every day and I get to help women in usually one of the best days of their life.

Nursing school. The remaining two participants went into the intrapartum nursing because of a positive experience in nursing school. The following participant

knew she wanted to practice as an intrapartum nurse from her experience in nursing school:

When I did my clinical rotations in nursing school, I didn't know what I wanted to do. I knew I wanted to be a nurse, but I didn't know what kind of nurse. I fell in love with labor and delivery when I had one of my first clinical experiences on this unit. Labor and delivery won me over in a big way.

Changes in nursing care practice. Several of the participants specifically spoke about changes they have experienced over the many years of nursing practice, mostly in a concerning tone. One participant acknowledged that while she still enjoyed caring for women in labor and birth, there have been changes.

I love the patients, working with them. I think our population has changed a little bit. Yes, it's changed. The hospital has changed. Certainly, the way we provide care has changed. Patients' expectations have changed. That was just one thing that I learned – when you have 39 years of experience, you incorporate what you learn along the way, and change your practice based on how things go, and what you learned.

The following participant described some of the changes in maternity practice that evolved over the years:

I think years ago we had just more normal, low-risk women in labor. We had more people up walking; they weren't on pit (oxytocin). They weren't on the monitor 24/7 (referring to continuous fetal monitoring).

They didn't stay in bed, we'd do a 20-minute strip (monitor the fetal heart rate for 20 minutes) and they'd walk, and then once an hour, we'd do a 20-minute strip. We did it all the time! I hardly ever get to do that anymore.

When asked why she thought this was, the participant replied:

Because so many more seem to have complications and they -- you know, I don't know how many people are being induced, but it just seems like it's getting more and more.

No matter how the participant ended up in the intrapartum setting, they all believed in the significance of birth as one of the most important events in a woman's life. For the participants that chose intrapartum nursing based on personal experiences, those experiences were both positive *and* negative.

Research Question Three: *To what extent do intrapartum nurses think that their beliefs affect the way in which they provide care to women in labor and birth, and what factors influence this?*

Intrapartum nurses beliefs about childbirth have been previously categorized into five underlying beliefs (see Research Question One). The following section explores the ways in which these beliefs are translated into practice and the factors that impact care. Linking participant's beliefs with the way in which they provide care was based on the participant's storytelling and best birth scenarios.

Findings for Beliefs one through four are presented together, given their significant overlap.

Acknowledgment of birth as significant event, for the women giving birth and the intrapartum nurse. For many participants, nursing practice was informed by beliefs about birth as a significant event and the personal satisfaction they found in being a part of a birth. As one participant described:

I just have such reverence for what's happening when a baby is born, and I think as my practice has gone on, as I've been in it longer, there are different things that I've focused on. Sometimes I'm really interested in watching the dads' faces. Sometimes I really want to ask the mom to touch the baby's head, and I tell her how cool that is, and maybe try to (get her to) help bring the baby out when the baby's delivering. So I kind of focus on different things. And it's such an -- I always felt it was such an opportunity to make a difference in their lives.

Similarly, another participant stated:

I hope that the women that I care for feel really good about what they've just accomplished, and empowered by their birth experience. I like that so much.

Talking and listening. Because all of the participants believe that a woman's choice should be acknowledged and supported, they described a practice that entailed talking and listening to what women had planned for their birth, and what their preparation had been:

. . . Every patient you get, you have to really sort of -- it's really important to you, as a nurse, to figure out what their plan is, or if they

even have one, where they're coming from, in terms of how much you interject your own beliefs. But I think the key is to -- to talk to the patient, to listen to them, and take the cues from them.

Patient advocacy. For some participants, beliefs about women's choice translated into a fierce commitment to patient advocacy. The following participant described an example of patient advocacy when a woman had been planning a birth in the Alternative Birthing Center (ABC). The plan was changed before labor and the woman was scheduled for a postterm induction on the labor unit. Once the woman had cervical ripening, she went into a good labor pattern on her own. Even though she had been admitted to the labor unit, the participant advocated for her to be moved to the ABC, which is not standard procedure. When asked about this, the participant replied:

Because that's what she wanted. And as long as we've got her into a good pattern, why couldn't she could go there, what's the difference? You know what I mean? I said to the charge nurse, " she really wants the ABC. She's in a good labor. She doesn't need Pitocin (labor stimulating drug). Just let her go do her thing."

Some participants discussed the difficulty of supporting a woman's choice when they knew that the patient was not fully aware of the risks associated with medical interventions. Almost all participants discussed this in relation to an epidural administered early in labor. Participants believed that even when it was a woman's choice, early stage epidurals were something that should be avoided. Further conversations revealed that the majority of the participants would try to encourage women not to get an early epidural.

I see it day in and day out, ... but if I have my way and I can keep that mom up, walking, (and the provider doesn't) break her water until she gets really into labor, make her really get into labor before she gets the epidural and can engage that head in a proper way, then I have a good shot at a vaginal delivery.

A second participant explained:

I don't want a woman who is in early labor to get an epidural, because I know it's going to slow things down, and maybe it's going to be a problem. It could make the baby turn OP (occipital posterior, or "face up"), it could be detrimental to having a vaginal birth. So when a woman is in early labor and they want to have an epidural I try to encourage them to do other things until they're at their wits end, because I know it's better to wait.

Ultimately however, participants said that they tried to support the patient regardless of the decisions made. As one participant explained:

I try to encourage them to do other things, to try something different, move in a different way, if they're on the rocking chair, have them get up and walk, or go to the (labor) ball, or maybe go in the shower, anything like that. And if they still want the epidural, I just make sure they're informed about what the benefits and the risks are, and they understand it. But if they really, really want it, then I have I mean, I help them. I help them get it. But I try to keep them going until I know they can't do it anymore.

Similarly, a third participant said:

Yeah. I'm not going to talk somebody out of an epidural if that's their birth plan, that's the plan that they want. But what I will do is give rationale evidence-based explanations of why at this point of time (in labor) maybe it isn't the best time for her.

Understanding birth preparation. Beliefs about the importance of women being prepared for birth were also reflected in how participants cared for women in labor and birth. For this reason, many participants described efforts to understand what type of preparation a woman had for childbirth, who her support people were, and what their knowledge level was:

It is so important to support her and to help her, and also give her support person ideas if they seem like they're not sure what to do, because they're usually nervous and they often don't know what to do. So I try to support her in that, and I try to learn what she really knows about different interventions, about pain management, about augmenting labor, about rupturing water, anything like that I try to figure out if they really know the impact of those interventions. And encourage her, and let her know she's doing a good job, and let her know I'm there to support her in whatever way she goes.

Influencing birth outcomes. Belief number five, *Intrapartum Nurses are Experts in the Care of Women in Labor and Birth*, was a consistent theme throughout the interviews. As experts, participants maintained that nursing care practice, informed by their knowledge, skills, and experiences, could significantly influence birth

outcomes. Many of the participants expressed the belief that when a laboring woman listened to their suggestions and accepted their guidance, nursing care had the potential to positively influence the birth experience:

The thing is that you have to encourage the patient. It's, "Hey, let's do this and let's do that. It's the rapport you establish with someone and the influence you have. I've heard some of the nurses say, "This is my room, and in my room I do things this way, or that way." I think most of us (nurses) are very confident that we have the skills to help women give birth.

A second participant voiced:

I think -- I know the things that I can do for a mom who's pushing that can change the shape of her pelvis, there's so many different things that I can do even with her labor, with when they get their epidurals. There are so many different things that I can impact that, sure, my C-section rate's probably a lot lower than some peoples (meaning other intrapartum nurses).

And a third participant described a birth story where her set of skills positively impacted the outcome of the birth:

I knew that my care, the nursing care that I provided kept her out of the OR. And I also knew that if I hadn't gone above and beyond using all of my skills, that she would have had a different outcome. I also realize that maybe if she had had a different nurse, she would've -- she may

have had a different outcome. So I got personal satisfaction in helping her.

When specifically asked if nursing care influenced “how things go,” the following participant further emphasized the effect of nursing care on labor and birth:

Some nurses think that, “Oh, God, she (meaning laboring woman) wants to do it (birth) naturally,” and that they don’t really know how (meaning they don’t feel comfortable with their skills) or they don’t want to take care of someone who wants natural birth. It’s funny because it just depends on the nurse. So, yeah, I definitely think a nurse influences how things go. It’s what message you give; however you’re giving it. If you are a tired nurse. If you are an impatient nurse, if you don’t want to be bothered with that patient, or you want to sit out at the desk and talk to your friends (other nurses), then you’re going to subtly suggest an epidural.

Guiding and supporting patients. The majority of participants voiced that their skills and experience were the source of their ability to guide and support patients. One participant described her expert intrapartum nursing skills were especially important when she was providing care to a young mother, who needed more support and guidance in labor and birth:

And I think a great birth is --maybe it’s a teenager, who doesn’t know what the best thing is, and she doesn’t understand. She’s been watching *The Baby Story*, but because I have a lot of knowledge, and I have a lot of passion for it, I can help guide the experience, the labor and the birth,

to make it a beautiful birth: low lights, her family holding her head up, her -- when the head's delivered and the shoulders are delivered, her pulling the baby up onto her chest. I think that's a good birth. I think those are great births.

One of the participants described the importance of "just being there" with a woman in labor, meaning the importance of physical presence, not necessarily doing anything with the laboring woman, just being by her side. She made reference to an older, more experienced midwife:

Well, I mean, I can remember the older midwife that knitted. Do you remember her? She was the first person that I thought, "Oh my gosh, she's just there." But in all my career I had never witnessed anybody who was just there. So I learned from her. I thought it made a difference, just being there, whether I've got a magazine in my lap, or... just being there.

As discussed in the literature review, once a woman has an epidural placed she may be subjected to cascade of medical interventions, and her movement is restricted. The following participant described how caring for a woman with an epidural can become very task oriented:

Yeah. So you're there and you're supporting them but you don't have to support them in the same way (as a woman who is having natural birth). Because they're more comfortable. They're not in pain. They're not in labor, well I mean, they are in labor but they don't seem like they are in labor, because they have an epidural. So once you get to the point of

having an epidural, then basically you're taking care of your patient's bodily functions, making sure they're hydrated, making sure they're -- have output (urinary). Do they need a urinary catheter, and you put it in. Continuous monitoring. And now you might need to start some medication, because the epidural's knocked out their labor. So you end up with a ton of interventions. And so it becomes much more technical. And I think some of the nurses like more of the technical part of it.

While many of the participants believed that their expert nursing practice had the potential to influence maternal/newborn outcomes, all of the participants identified at least two or more factors that influenced the way in which they provided care to women in labor and birth.

Factors influencing intrapartum nursing care. Participants identified factors that they perceived interfered or challenged the way in which nursing care was provided to women in labor and birth. The changing face of today's generation of childbearing women, the high rate of induction of labor (the initiation of labor prior to the onset of spontaneous labor), organizational factors, the fear of litigation and the unpredictable relationship with the attending physician were identified as factors influencing how the participants provide nursing care.

Today's generation of childbearing women. One of the most salient themes to emerge throughout the interviews was the idea that today's generation of childbearing women are different than generations of the past. The majority of participants believed that women today were not prepared for the rigors of labor and birth and/or had

unrealistic expectations. Several participants spoke about a lack of endurance for the pain associated with childbirth. As one participant stated:

I think now they (women in labor) just -- I don't know, they just don't want pain. They just don't want the inconvenience. They all want to know what they are having, when they're going to have their baby, what time... They don't want the mystery of it.

A second participant stated:

But a lot of our patients come in and they expect to have no pain. I think that's the general philosophy. They don't expect to feel anything. So, I think, you know, now their expectations are of comfort and -- they just want it (epidural) so much earlier. You know? And so the big question always is, "When can I have my epi (epidural)?"

Several participants said that women requested epidurals either before or as soon as they had the slightest pain associated with labor and birth. When asked about whether or not women had changed from past years, a participant answered:

This is a change from past years, yes, very much a change. Because their (women in labor) plan is you go into the hospital when her doctor's on. (laughter) You know, if they had their way for what they want for their perfect birth experience, they don't suffer. They don't want to feel labor pains. (laughter) And do I fight it anymore? No, and I feel badly about that. It's a bad, bad way to be. But, I'm glad I'm at the end of my career, because I think this country's going to be very, very sad when the complications come.

The following participant explained what she usually said to women when their first question was “when can I have the epidural?”

What I say to them is, “When you need it.” But then I like to have that discussion about what that actually means. What does it mean to them? And, what are their expectations...? But their expectations are all so different. Today, most women come totally unprepared to deal with labor.

Additionally, one participant described that she believed women had come to de-value the hard work of labor and birth:

What’s the problem with women today? The problem is that they don’t value it (birth). So the thing is that they are -- in their mind, they don’t think there’s any difference in having all the intervention or natural birth. If a patient who’s normal, is low risk comes in and wants an epidural, most of them don’t think there’s any value in waiting. They’re going to get the epidural as soon as possible. -- And I’ve even heard them say, “You’re going to get the epidural anyway. So why not now?” And there are patients who want the epidural before they even start the labor. Patients ask for that.

Similarly, half of the participants either alluded to or spoke directly about women in this generation wanting to have their baby when it is convenient either for her, the family or the physician. As one participant stated:

And again, that’s our culture, that’s where society comes in. “This is a convenient day for me. I’ve got my kids in daycare. My husband took

the day out of work. I like this birth date.” Whatever it is, that’s part of society’s demand.

When queried about the rationale for this generational shift in women, several participants cited that fewer women were attending childbirth education classes. This appeared to have an impact on labor and birth. Instead of attending classes, almost half of the participants commented that many women reported that childbirth reality TV shows or the Internet were the primary source of childbirth education:

I haven’t been to a childbirth class, so I often wonder what -- who’s teaching them and what do they actually teach these days? Then, of course, more recently, there’s the Baby Story, (reality TV show) which people seem to think is the way to learn about childbirth. There is also a group of families that just, it seems like they don’t even think about it. They don’t even think that there might be something you might have to know about having a baby. They really place their health and -- almost, they place the whole event in someone else’s hands. It’s kind of odd, it becomes my responsibility for getting the responsibility.

Another participant emphasized:

They’re (pregnant women) learning about it (birth) through the Internet and cable TV. And in a half an hour TV show she’s (women in labor and birth) ripened (cervix ready to be induced), labored, had an epidural, pushed three times, and has the baby. That’s their model of childbirth, and many women these days expect this when they come in.

Discussing the impact that the Internet has on childbirth, a third participant stated:

I don't know, it seems like people (pregnant women) are reading too much online. And they read something, and it's online, so therefore it must be true. And I think the people that do that, they don't have the trust in their practitioner, their doctor and midwife, or the nurse taking care of them, because they're just focused on whatever they read online. And they can't always explain why they want a certain birth plan that they read online, but because it was online, so it must be true.

Additionally, one participant noted that women in previous generations relied more on the help of labor "coaches" (person present as support to the laboring mother):

I think their (women's) perception of labor and birth has changed. I think women don't want to be in any pain. Before, I think most people, knew that when they were in labor they could usually count on the person who was coaching them. Because when I think about how we (nurses) run the labor room, we have almost always had two patients. And we would always go back and forth (from room to room), and it seemed like they understood that you were going to be with someone else, too, and they didn't expect that constant pampering or the constant presence of a nurse. They (women) just knew that they would have to get through some contractions without you (the nurse), and you'd be right next door. It was as if people (women) just knew that they had a coach for a reason, and they took childbirth classes. Some women look

at you like, “I’m not going to have an epidural, but take this pain away from me (laughter). It puts a lot of pressure on us as the nurse.

Some participants said that this change in childbearing women originated from a general generational shift in attitude. Specifically, a few participants described today’s culture as one of “instant gratification”:

It is an “I want it now” generation, “I want everything planned,” what we used to call Type A personality, a control over everything that happens in their life.

A second participant stated:

I think that this is a microwave society. The women having babies today come from a generation where they’ve never had to suffer. They had a headache; their moms gave them Tylenol. They’ve had microwaves. They’ve had the Internet. They’ve had -- everything comes to them so easily. And so they’re not willing to wait, and if the physician says, “We’re going to induce you,” they think “good.”

Elaborating on the theme of instant gratification, another participant spoke about how so many women opt for induction of labor as a convenience and then become impatient when it takes longer than they thought:

Some women will say: “This is taking too long. I’ve been in labor for two days now.” “No, you haven’t been in labor. We’ve been ripening your cervix and getting you ready to go into labor.” And they will say, “I just want it over and they aren’t even in labor yet.”

Similarly, a third participant explained:

Well, maybe there were better childbirth classes (in the past). I don't know. I feel like they're not prepared about what's going to happen, even from their provider. We do a lot of inductions, and it's just – people have no clue. It's like “Am I going to be done by five?”

Another participant proceeded to give a specific instance where the procedure, artificial rupture of membranes was requested by the patient:

Recently, I had a girl (in labor) that was, quote-unquote, in labor for two days, while we were trying to get her ready to go into labor, and she did not want to wait for a second day induction. She wanted them to proceed and break her water. She was not ripe enough (cervix ready for oxytocin to be effective). She was not in labor. The (baby's) head was high (in the pelvis). And I said to her, I said, “Do you know that if you do this, it greatly increases your risk for a C-section?” And she said, “I don't care. This is taking too long. I want a section anyways. Why don't they just do it now?” And that's pretty much the way things went for her, intervention that didn't work, and then a C-section.

Some participants perceived a connection between preparedness and patient satisfaction. As one participant remarked:

There's so much talk in the hospital about patient satisfaction but I think what dissatisfies them the most (women in labor), is not being prepared. It sets them up for dissatisfaction.

A second participant described what she perceived as today's culture of women combined with the culture of her maternity setting as barriers to 'natural' birth:

Get them in, get them out. It's an organizational attitude and it's a societal attitude. I'm (women in labor) not supposed to be uncomfortable. I love it when you hear women, especially the young people say, "Hey, I'm supposed to be enjoying this." And I think to myself I don't remember where that's written about labor and delivery. You're supposed to be enjoying yourself? I think it's an expectation they have. I also think there is a general lack of confidence that women have to give birth naturally, that's the reasons women don't let labor begin on its own. And what stops us (the nurse) from encouraging women to go natural is the culture of the labor room; the computer, the documentation, and all the monitoring.

Women and the co-morbidities related to obesity. More than half of the participants associated the increase in obesity in today's generation of childbearing women with what seems like an increase in the number of high- risk pregnancies, specifically preeclampsia and gestational diabetes:

I mean, people in general are just getting big, and it's -- I mean, it's a shame to be so young and have so many problems already. I mean, if you're a diabetic and you have high blood pressure, and you're 28, 30, there's going to be a problem with your pregnancy.

A second participant also associated the co-morbidities of obesity (preeclampsia and gestational diabetes) as presenting complications in pregnancy and labor and birth:

Because of obesity, women just have more complications. I mean, the diabetics, the pre-eclamptics, and gestational hypertensives, I don't remember this many in the past. They put themselves at risk for an induction because they have issues related to obesity, you know.

Women with complications end up staying in bed, and I just think getting in that bed is just like, one of the worst things. But, it seems that there's less and less just nice, natural, normal people, I mean patients that are admitted for labor. So many people are high-risk. They have problems.

A third participant further elaborated on this issue and specifically discussed the impact on nursing care at the bedside:

I do see normal, but I see a lot more high-risk. My biggest thing lately is obesity, and what comes with it: the gestational diabetes, the high blood pressure, the interventions at birth because of not being able to get patients in positions that are better for delivery. I don't know if it's an official epidemic, but we do know that there's a lot more obesity and that really lends itself to more to more intervention. And it also makes it more difficult to monitor the baby, monitor her contractions; therefore their labors are longer. Are they truly stuck (in regards to labor progress) or are we just not able to monitor properly? I think they end up with more intervention, like internal monitors for that reason. But I find that with more and more women being obese, there are more and more complications and interventions.

Another participant considered the idea that women who are socioeconomically challenged have pre-pregnancy underlying health issues which end up affecting their risk status in pregnancy:

Those are the two (gestational diabetes and preeclampsia) that I see constantly because of obesity. I also think that some women just don't get good primary care, either by choice or because they don't have money, they don't have insurance, and then they don't get their insurance until they're pregnant, so their first real primary care that they've seen in a while is an OB (obstetrician). So could they be diabetic or hypertensive prior to pregnancy that was never caught? Maybe if it was controlled earlier it wouldn't really be an issue at delivery.

Induction of labor. The rate of induction of labor was perceived as another factor influencing nursing care by a most of the participants and seemed to be linked to this generation of childbearing women and their obstetricians.

Only one participant thought that the rate of induction of labor was getting better and more than half of the participants expressed concerns about inductions of labor, especially related to the amount of technology involved and lack of informed consent. When asked if many women arrived at the hospital in spontaneous labor, a typical participant response was: "Rarely. But it's awesome when they do." As another participant said:

I hate them (inductions). I mean, well, when I think about "labor beginning on its own," I think of, when I go in to get shift report, or

give somebody (nurse) a lunch break, and on the SBAR sheet (comprehensive written report of patient history) it says ‘admitted for labor’, it’s like, “really? This is a labor patient? (laughter) As opposed to an induction? Wow.” It’s like so many women come to the unit for induction of labor but not actual ‘labor’.

A third participant stated:

It (induction) interferes with the normal birth process. And it seems as if there are so many more reasons than there used to be, and I don’t know if it really makes an impact in the outcomes.

Participants discussed the concept of informed consent for induction of labor.

They asserted that many women don’t seem to be well informed about the entire process. According to one participant:

I don’t think inductions are really explained to the patients. On admission, when I say to them, “Well, you may come back tomorrow for a second day,” they (patients) say, “It’s not going to happen in six hours? But they didn’t tell me that.”

When asked about informed consent and if the nurse’s role has evolved over the last decade, the same participant replied:

Yes, but it shouldn’t necessarily be this way. But it is, and it has become part of my job with inductions.

Several participants believed the pregnant women and obstetricians both had a stake in the rate of induction. Women ‘want them’, they are uncomfortable physically

toward the end of a pregnancy, they get tired of waiting and it also becomes a matter of convenience for the pregnant woman and sometimes the obstetrician:

Well, I think that a lot of times the bottom-line is convenience. “My mother is here this week from out of town to help me with the baby. Or my husband has to go on a business trip next week.” Those sorts of things.

Another participant stated:

I think it’s part of the culture of convenience. I think it’s, “I’m not going to wait for my due date, I want to have my baby now. My doctor’s on today, I’m going to have the baby now. I have a babysitter, I want to have the baby now.” So I think that there’s a lot more medical intervention that doesn’t need to be there.

Similarly, a third participant discussed the role that inductions of labor play in accommodating busy physician schedules:

They do too many elective inductions, I think, and I think it’s because a lot of the practitioners (obstetrician or midwife) cross-cover with other groups. So, like, you’ve (pregnant woman) been going to a group of three or four doctors, and you’ve met them all, and you like them. Then the day comes to deliver and doctor “who knows who” is on, and you’ve never seen them before. And they can be a totally capable physician or midwife, or whoever, but you don’t know them. So I think it makes some of the physicians book inductions so that they can deliver their own patients, and women are happy about that.

Further discussing the concept of the physician-patient relationship and large obstetrical practices, the following participant states:

I don't feel that the physicians truly know the patients anymore, which makes me have to know my patients even better. Sometimes they come in and start talking to the patient and they don't necessarily know who the patient is. I mean, there's a possibility in a 12-hour period you (the nurse) could be the one (consistent) person at the bedside, and there really could be three different physicians caring for that woman. It's not unusual. So, it's really not uncommon at a birth that the nurse is really the only familiar face to the patient.

Organizational influences. Participants identified organizational factors that influenced nursing care. In particular, several participants said that the hospital environment was like a "business" or "factory" which emphasized a high patient census over quality of care. As one participant said:

Get them in, get them out. It's a factory like mentality that causes us to keep intervening with our stuff (birth). We're all in a hurry. And I don't know if it's because we're backed up, our unit has 20 labor beds, do you know what I mean? It's like get them in, get them out, because if you don't get them out there's no place to put them (women in labor)... and we have a rule in the labor unit, when you're a nurse and you have a patient, you have to be actively managing them.

In relation to the birthing unit, one participant described the efforts she made to protect her patients from the rushed, factory like culture of the unit:

Because we're a factory. We operate like a factory. And I feel as though maybe when I'm in my room I try to be a shield a little bit to try to protect patients. But I had to come up with a saying years ago. I said to myself, to ease my pain or whatever, I would say, "You can't protect women from their significant others, and you can't protect women from their provider (physician).

Suggesting that the organization's administration was very focused on the business side or economics of maternity care, one participant said:

In my opinion it's about, business...trying to please a consumer. That's what it's all about. It's business-driven. And we're competitive with other hospitals. And even though it's a non-profit, it's also a business. And we want to attract patients to our business, so we're always trying to please the consumer. So if the consumer wants their epidural when she's two centimeters, they could get it.

In a similar light, a second participant emphasized the "consumer" aspect of providing care.

... Patients are not patients anymore, as much as they are clients.

They're like customers.

Several participants said that the increasing economic priorities of the hospital influenced how they were able to practice nursing care:

I mean, I can say that most of our patients that deliver vaginally do get epidurals, and with that goes the interventions, so maybe that is typical.

I would imagine it's like that in most big hospitals that do a lot of

deliveries, because we have 24-hour anesthesia more so than community hospitals. So maybe the nursing care becomes the nature of what the hospital can provide economically (meaning what kind of services the hospital is able to provide the patient with).

The following participant explained that the business priorities of the hospital could challenge the nurse's ability to support women in natural birth:

And that's (the number of births) what we're (the organization) getting paid for from the insurance company so when you go and whine to them (administration) about it's really not conducive to natural births to have nurses be taking care of so many patients, they're like you've got to be kidding, right. Their attitude is like, "We don't care, we need the numbers."

When asked about how patient census influenced nursing care, the following participant compared a birth on the busy birthing unit to a birth in the ABC, where women were not hurried to recover and had no anesthesia or EFM:

Oh, I think it does. It's just such a huge volume, and there is a push to get that birth done. It isn't as personal. If you're doing one birth, say in the Alternative Birthing Center, you're covering someone (this participant doesn't usually attend births in the ABC) for 3 hours or you're helping them with breastfeeding, there's no real rush to get them up (to the postpartum floor). Because the expectation is that the patient will get a slow recovery and have time to be with her baby and their partner, versus the urgency (on the other unit). It's, like as soon as you

can bend your knees and lift to move (effects of epidural have worn off) you move the patient. And then you're going to get another patient. So it's the volume. It's not the same kind of experience where you (the nurse) have time to process that delivery and be a part of that birth.

Staffing patterns. Staffing patterns were also identified as a factor that influences nursing care:

I feel like, because of their staffing issues on nights, that they have a lot more pressure to get patients out quickly. I don't feel like I have that on days.

In relation to adequate staffing on the birthing unit, another participant discussed the importance of staying with a woman when she is trying to have a NPB, meaning one-to-one nursing care:

You can't walk out of the room. You have to stay with her. You have to be with her, (emphasizing "with"). There is a real problem on this unit, which is, if the unit is busy and your patient doesn't have an epi (epidural anesthesia), they're (nursing management) going to give you a second patient. It's the exact opposite from what it should be. I don't know why, but they give you a second patient. It's very counterintuitive. If you complain, you risk sounding like you're a spoiler and you don't want another patient and you're complaining about your assignment. There are times when they say, 'Sorry, there's nobody available' (meaning another staff nurse), and I'm not kidding, I can't do both, so it's awful... You walk out the door and she says to her

husband, 'I want an epidural.' And you know that you can't stay there because you have another patient.

A second participant noted that the number of patients assigned to a nurse affected the way in which care was provided:

Because you can't just spread us so thin and expect us to provide the most essential part, which is the hands-on care of the patient.

Electronic documentation. Electronic documentation was commonly reported as a factor affecting nursing care. The majority of participants described the requirements for documentation as burdensome and distracting, sometimes necessitating the nurse to choose between documentation and patient care. When specifically asked about electronic documentation, one participant emphatically replied, "Yeah, it's like having another really needy patient in the room." She then went on to describe the impact:

Well, it makes you change your practice because you literally cannot take care of somebody while you're typing. And you're forced to type because they audit your chart. They (administration) say, 'Excuse me. I didn't see that you checked this checkbox after you gave that patient pain medicine.' So they're watching. But they say to us, 'Always put patient care first', then they will come and find you and say, 'You didn't check the checkbox.'

Another participant explained that balancing patient care with the demands of documentation could be difficult. As an alternative, she suggested that dictation might allow nurses to spend more time at the bedside caring for their patients.

I hate to say it, ... but I think if we had like a dictation thing so you could dictate your care, you might be able go back to more personalized care... because I don't think physically, you can get your work done plus all the documentation in the computer. You just can't fit it in. My documentation is not as should be. I will put the patient before the documentation but my documentation for second stage is atrocious. Because I'm involved in getting the baby out, and so my documentation sometimes -- (laughter) I'll say, "Oh my God, I haven't written anything for the last hour."

Another participant remarked that acute care nursing made the requirements of electronic communication particularly difficult.

I don't mind the computer. The only time I mind the computer is after a C- section. Because there is so much to put in (documentation) and there's so much to do with the patient. And that's when I feel overwhelmed.

The participant went on to say:

So when the patient comes back from the OR (operating room), there's a lot to put in and a lot of numbers to keep track of. And people -- doctors are talking to you. Everybody's talking to you. And you're trying to write it all down so later when you have time you can then go in document it all. And the patient maybe she is bleeding. So there's a lot happening, you know? And she's in pain. And there's a ton of things you have to do. We really should have two nurses when they (patients)

come back from the OR so one can document everything that needs to get done.

When one participant was asked whether or not electronic documentation had an impact on her nursing practice she commented:

Well, I feel like in the prison that I live in (participant is referring to all of the policies and procedures she must abide by), about this required documentation stuff, I push the envelope as much as I can to try to make it all work, but there are some days I fall miserably short of that.

Another factor affecting how nurses provide care to women in labor and birth was the *medically litigious environment* of the birthing unit. One participant talked about the traumatizing effect of being sued or named in a lawsuit when the outcome of the birth was less than optimal. She upheld that the nursing culture on her unit was very “lawsuit conscious.” Several participants reported that their practice of care was influenced by a fear of litigation. This was especially the case for the nursing practice of continuous EFM. As one participant put it:

I’m terrified of being sued. Being named in a lawsuit feels really shameful and bad. So I think that these fears put their fingers out and make us want to monitor every patient, 24/7. Because what if some event happens when she is out walking, what if? It’s the lawsuit fear in the end is what gets us.

Another participant linked the litigious culture of the birthing unit to the practice of continuous EFM, maintaining that it was the culture of the unit that supported the practice:

. . . We're highly interventive. But it cracks me up. I was never on a fetal monitor, ever (referring to her own birth 30 plus years ago) and here I am so reliant on fetal monitoring. It's probably, I guess, because it's such a huge part of the culture, and because of constantly having to prove that the baby is OK as far as we know. So, it's a lawsuit thing. I don't know. But it's the lawsuit fear I think in the end is what gets us to practice this way.

It is evident that more than half of the participants associated the fear of being sued with the need to establish safety and the practice of EFM. Participants perceived EFM to be an accurate tool in establishing the safety of the mother and fetus:

Basically what I expect is based around safety of the baby. So if I see something on my monitors (fetal monitoring) or I need her to change position, or to do something, or not do something based on what I'm seeing on the monitor, for the safety of her or her baby, I expect her to follow my guide.

As such, participants' reflections suggested that EFM practice is widely accepted as the routine, and intermittent monitoring is practiced, but under only very specific circumstances. Some said that veering from the routine use of EFM was only rarely done. For example, the following participant needed a doctor's order if she wasn't going to use EFM:

. . . But if I'm not on anesthesia or Pitocin, and I don't need to have continuous monitoring, I'm perfectly happy doing a 20-minute strip (fetal heart tracing), or just listening to the heartbeat with contractions.

I'm perfectly happy doing intermittent. If it's ordered I will do it, and if it's not ordered and there's no reason why we can't do it, I'll ask the doctor for it.

Another participant also emphasized the need for a physician order to use intermittent monitoring:

I just don't want the physician to come in and say, "Why isn't she on the monitor?" You know, I make sure it's OK with the practitioner, but I need the official order.

The participant was then asked about her comfort level in using intermittent monitoring when caring for a low-risk patient. She responded:

Sometimes I'm not comfortable, but I try to do the best I can. I think -- maybe from my NICU days, I just like to see what's going on. But, I mean, if that's what they want (intermittent monitoring), I won't really argue that point, if everything is normal, and I feel it's safe. Sometimes I think it's (intermittent monitoring), in some cases, when they get active -- and I think it's every five minutes, you're supposed to listen -- I mean, it's (intermittent monitoring), clearly more work for me, but I think it's more annoying for the patient too, because then you have to find it (the fetal heart rate) again, whereas if it's just there (EFM), I think it is easier for both of us (patient and nurse).

A third participant also discussed intermittent monitoring:

I like the monitor (laughter). We have telemetry, which usually works. I don't have a problem with someone not being on the monitor all the

time if they are very low risk and I've had a good tracing of a very active baby.

Notably, one participant discussed EFM as a flawed method of establishing fetal well-being and suggested that the intrapartum nurse must actively engage with the physician (or midwife) in order to provide care for women outside of the standard orders. She pointed out that some of the nurses she worked with were more experienced and had more confidence to avoid the routine use of technology, particularly EFM. The participant stated that the standardized orders for patients admitted to the labor and birth unit included EFM and many of the nurses would just follow orders and not question:

Routine care, I don't like it. I mean, I think you need to look at what's happening with the patient. Not everybody needs an IV. Not everybody needs Pitocin. They don't all need continuous monitoring. We know that fetal monitoring is totally flawed, and so I think we should be offering less intervention. I think that if it is a low-risk patient, then they should have less intervention.

When asked if she could practice this way in her current work environment:

I can. The power forms, (standardized orders) they automatically have continuous monitoring. I can call the doctor or I can text the doctor and say, "She's low-risk. She's contracting. She doesn't want an epi (epidural) yet. She doesn't want any medication. I'm going to do intermittent monitoring." And they're usually fine. I just have to make the effort. And I like to do it. And I will do it. And I will avoid the IV, I

mean, that's something that makes a difference, I can make a big impact in that way.

She further discussed:

I think a lot of people (nurses) just follow the doctor's orders, and they don't question it. But most of the women (nurses) that I work with have a lot of experience, and they've been there for a long time. So we've got a lot of confidence that we know what the right way to do things is. So I think that there are nurses who will ask for the intermittent monitoring, or will ask for low intervention, because they really care about it. But there's some that are still more, I guess I want to say old school, and they just do the IV, they do the monitoring, and they don't question. They're going with the routine, and they're not questioning. They're not necessarily older nurses either. But there is that element, definitely.

Relationship with attending physicians. More than half of the participants mentioned the interaction and relationship they had with the attending physician(s) as a factor that potentially influenced nursing care. While a couple of participants maintained that the relationship between the nurses and physicians was improving, most participants described this relationship as unpredictable and said that nurses were not consistently viewed as an equal member of the maternity care team. One participant stated:

“I really don't think nurses are taken as seriously as they should be, as far as knowledge and... I think there's still barrier to that, between that physician-and-nurse relationship.

A second participant emphasized the unpredictable nature of the nurse-physician relationship:

Because there are some doctors who will just let you be... run the show (labor management) for the most part, all day long. They'll say, "Call me if you need anything, otherwise I'll be around every few hours."

And there are other doctors that are there (in the labor room) every 59 and a half minutes, making sure that there's progress. And then if there's not progress, there is more medical intervention, so that that clock is always ticking, so to speak.

A third participant said, "Certain providers will listen (to us) and then there are those that will not." Another participant pointed out:

There are some physicians, I know I can say something to them, and they'll listen to me. And sometimes, they'll do what I think is best. But they're not all like that.

The following participant described what she thought was an improved relationship with physicians, but also alluded to some doubts about being considered as an expert in intrapartum care:

I think there are more providers that will listen than there are those that will not. I think that's getting better. I think the med teams (simulated teamwork) have helped that a little bit. And I think people are at least listening, maybe. If I call someone (physician, resident) out on something, you won't get," You're right, I was wrong," but I think it's food for thought in someone's head. Maybe they won't be so quick to

do that again. So I think even if there's no immediate apparent result, there might be long-term. So I think it's worth a shot.

A second participant described a dismal view of the relationship with some attending physicians:

I think they listen sometimes to us because they have to, in a way, because they've kind of been told to, that it's supposed to be collaborative, but I don't think deep down they really want that, now. I think that they just want us to be a little helper that just cleans up and like an assistant that does all the gut work while they do what they have to do.

Further expounding on the unpredictable nature of the nurse-physician relationship, two participants initiated conversations about "board rounds," a process where all health care providers gathered at a central location on the birthing unit (traditionally considered the "nurses desk") twice a day to discuss patient care. This was created to improve communication and professional collaboration with all health care professionals involved in patient care on the unit. Two of the participants provided very different perceptions. The first participant was more positive. When asked if she thought her voice was heard as important input for patient care, she replied:

I don't think it is. No, I definitely don't think it's equal but it's always heard. At my institution we do board rounds, like we round with all the other doctors and nurses. So we have had a shift in our culture, which has been positive for sure.

So that's been very beneficial for the patient, and the family, and their birth experience. So, yeah, I mean I definitely think we have an impact, it's just that we're not always heard. But we could be heard even more.

The second participant was outwardly disappointed with the nurse-physician relationship and the ability to collaborate on patient care:

I think more is expected of the nurse now. We have a lot of responsibility, but ultimately, I really don't feel that most physicians want to collaborate with us. I mean, you've been to board rounds. They don't really show up, most of the time. They don't really take it as seriously as they should, I don't think. I mean, the whole idea was, you know, go and see your patients, collaborate with the nurse, so that when board rounds comes at ten o'clock, everybody's on the same page. And you still see nurses asking questions, still in the dark about patient care.

Almost half of the participants described a subtle defiance in avoiding confrontation with the attending physicians. This occurred when the nurse recognized that the physician's plan was not supportive of the patient's plan. This was especially true when a woman was trying to achieve NPB. The following scenario was an example of subtle defiance. This participant believed the woman was coping well with her labor contractions. The physician ordered oxytocin. The nurse believed the oxytocin would lead to a more intense labor pattern. A more intense labor pattern would increase labor pain and most likely push the patient over the edge. The participant stated she started the oxytocin but kept it at a very low rate. Thus, she

didn't actually go against the physician order, but she subtly defied the order because she believed the woman was progressing and coping well just the way things were:

Sometimes you can talk to people (physicians) and say, "She's really doing well and she doesn't want an epi (epidural), and I think the Pitocin (oxytocin) will put her over the edge, and they will listen. But some physicians won't listen, so I start the Pitocin and just leave it at two (low dose). So, I did what they told me to do, but they're (physician) not going to sit (in the room) and watch me and look at how high I'm going on the pit (Pitocin). So, sometimes I feel like it's not worth the fight. I just start it and -- I mean, what's two milligrams going to do?

A second participant supported a similar subtle defiance related to the use of oxytocin:

You're (the participant) feeling like the patient's doing really, really well. You don't want to fight because you just don't want to. So, you find a way around it. I think it's just -- you see so many people get so worked up, and you can't possibly get like that every single day at work. So, I would start it (oxytocin), but it's at two. He's got his Pitocin, but I'm not going to put her over the edge so that she goes against her plan, you know?

A third participant talked about subtle defiance in relation to an amniotomy by the physician, which could significantly increase the intensity of labor contractions:

So really even though you know that this woman is doing well with labor, and if you (physician) break her water, the contractions will become a lot more intense, and then maybe we will need to start Pitocin, you feel like the buck has to stop somewhere. So I've said, "Could we just try it a little longer this way?" with attendings (physicians). And sometimes I've found that I hit a brick wall, because they don't always listen. But with the attendings I'll say, "Go to lunch." And they'll say, "I had lunch (laughter)." I'll say, "Have you had dessert?" And I try to lighten it up, make a little joke about it. "Have you had dessert? Don't you have to call your wife? Or have anybody else to go see?" I'm just trying to buy more time for this woman. But I'll only do that with them (physicians) depending on the circumstance.

At least half of the participants talked about the significance of the patient-physician relationship. Participants spoke about the importance of not interfering with the patient-physician plan even when it was perceived that the decisions made were not what the women had planned for, and was not evidence-based practice. When the following participant was asked if she would challenge a physician's decision to perform an unplanned cesarean delivery, she stated:

Mm-mm, there's not one person (nurse) that I know that would do that. But then again, I'm not in everybody's room, so, you know... Now, the nurse may come out to the desk when you're standing there, and may say something about it to the other nurses, though. But remember, this is the doctor that they chose. So I'm going to let that go today. Because

this is their doctor. And they do like their doctor. They have a relationship, some don't, but most do. And that's who they chose.

Another participant stated:

Because it's that contact between the provider and the patient, and she's known this provider for nine months, or -- and he says it's safe to have a C- section. I don't interfere with that relationship.

Yet another participant emphasized the same point:

I just think it should be more of an open discussion (with physicians). I don't think we should be afraid to have a discussion. It frustrates me that we have to be afraid to have a discussion about how we think it's going, and how we think it should continue. And sometimes I don't agree with what they want to do, but it's ultimately their patient (physicians), and the patient picked them to be their physician.

Anesthesia department. A couple of participants identified the physical presence of the anesthesia department on the labor and delivery unit as a factor that impacted nursing care even prior to a patient's admission to the unit:

At the "baby factory," anesthesia plays a big role in having the IV as well. They (anesthesia) have their own weight that they get to pull... they even dictate who gets to eat (in labor) and who doesn't.

Most women are required to have an intravenous line (IV) in place upon admission. Participant said "having the anesthesia department with us, they want that IV right from the get-go." Alluding to this as an unnecessary intervention for most

women, one participant believed that (anesthesia) focused more on childbirth as a danger waiting to happen, rather than knowing what to do if an emergency occurred:

They (anesthesiologists) look at it (childbirth) as a danger waiting to happen, rather than an emergency. I think we're perfectly equipped to be able to handle things on an emergent basis and I don't see why we have to have an IV in every single woman.

Clearly all of these factors influenced nursing care to some degree. Although participants believed they were experts in the care of women in labor and birth, and that women should be supported in their choices, it is clear that there were many factors that challenge nurses as they practiced in this modern maternity care setting.

Research Question Four: *What do intrapartum nurses perceive about normal physiologic birth and what are the barriers and facilitators for nursing practice that support and promote NPB?*

Most of the participants referred to NPB as natural birth, normal birth or birth without anything. Not one participant used the phrase normal physiologic birth, or physiologic birth. The majority of participants did not initiate conversation about NPB. Participants were either specifically asked about the topic of NPB, it was introduced within the context of a discussion, or was alluded to when participants described ideal birth scenarios. In order to generate findings for this research question, the interview was more structured. In discussion around nursing practices that supported and promoted NPB, participants identified more barriers than facilitators. So, while these narratives had the potential to be interpreted as a lack of support for NPB, many of the

best birth story descriptions reflected the participant caring for a woman experiencing NPB. One participant described what she considered her ideal birth scenario:

I guess there's nothing that I enjoy more than women who are almost hypnotic, the way they breathe through contractions. They're not afraid. They may go, "Ow, ow, ow." But they actually -- they do it. They just breathe through the contractions. They know they can do it. They want to do it. They believe they can do it. And it's not interventive. It's like I'm just there to make sure they're safe. They are doing it. And that, to me, is probably the best kind of birth experience that I could humbly be a part of.

A second participant described a birth she loved:

If somebody comes in screaming and out of control and is like seven centimeters, they absolutely should get an epi (epidural), if that's what they want, sure, yes. But if they don't want that, I love that. I love to work with them and make it happen (naturally) and be flexible with how much I have to monitor her, and to try and help her be comfortable. And I would stay with her. I would never leave someone like that.

When the following participant was asked the question, "Do you think there is any benefit to woman experiencing NPB?" she replied:

I think that if it is a low-risk patient, then they should have less intervention. Yes! I've had two natural childbirths. I think it empowers women.

When another participant was asked the same question, she described her favorite birth story:

My favorite birth is when a woman is just willing to let it happen.

There's no birth plan handed to me. She can communicate her plan. She lets it just happen, that's her plan. And that's the patient that will get out of bed at eight or nine centimeters and stand beside me. She wants to work with her body to be strong and get through birth, and I've had the most lovely births with those patients...

A third participant linked physician practices and the women's desire for a pain free birth with difficulties a nurse might encounter if they wanted to support and promote NPB:

I've heard some providers say, "When you get your epidural..." as if it is an expectation. So...it's like they encourage the patients to get an epidural. Then the woman will say, "Oh, thank God -- oh, thank goodness," whatever, that she got an epidural. So I think that they (meaning both physicians and laboring women) a lot of times don't really think that there's any benefit to natural birth. And I feel bad about that.

The following participant alluded to the value of NPB by comparing it to the act of going to the mountaintop, but was quick to emphasize the importance of supporting women in their choice(s):

What I say to women is, 'if you want to go to the mountaintop I'm going to walk with you, go up, go with you. And if you decide that that

isn't for you, I will support your decision.' But I'm not going to subtly tell her she's a loser if she doesn't go and ends up having an epi (epidural), because that's a problem too. Honestly I want to support the person (woman in labor) to make her feel good about what she did. And the feel good part about going on your own is fabulous, and a few make it. But not that many in our world. So I'm not going to go around guilting them and saying, 'If you don't go to the mountaintop what a shame.'

So while the participant did not specifically say what she believed about NPB in this narrative, she associated it with the positive metaphor of going to a mountaintop, (generally considered a physically challenging yet enjoyable experience, often reflecting a feeling of deep accomplishment). The participant also stated, "*the feel good part about going on your own (NPB) is fabulous.*" She implied that NPB was a difficult but positive experience for many women. The participant then went on to discuss why she supported women, especially women of today's generation:

In our society we don't have our mothers, our aunts, our cousins around us for two months to take care of us while we take care of our baby. We hit the ground running. We go home in one or two days; our husband goes back to work the next day or in the next two weeks. Our parents live in another state. We are alone with that child. We're going to be home for a very short time, maybe six weeks, and then we're back to work full-time and we're going to bring that baby to a daycare center. It's like we hit the ground running in our society. So if you get yourself

an epidural and don't stress your body out to the max today, I completely get (understand) why.

Further illustrating the belief that women should be supported in their choices, the following participant emphasized the importance of not interfering with patient decision-making, particularly related to natural birth:

I mean, I don't think everyone should be forced to have a natural childbirth. She may want it, but I don't think she should be forced to. It should be a choice of the patient. If that's what they want to do, fine. But I think the key is to -- to talk to the patient, to listen to them, and take the cues from them. And I'm not going to shame them. I think if I ever had children, I eventually would have an epidural...

The majority of participants believed that NPB, or natural birth took a healthy, motivated and prepared woman. The following participant was emphatic that some women were unable to meet the rigors of labor and birth without interventions:

Some women haven't had any experience in physical exercise, there's no evidence in her world that she's had any physical endurance. And, some women just don't have the internal fortitude to get through birth naturally. Nor does she have the physical capabilities. So because of her physical situation it's really hard. I know I keep going back to all of this but we see so many women who are giantly overweight and this tall (using her hand to indicate a woman who is shorter than average). And sometimes she just doesn't have what it takes.

A second participant stated:

I mean, there are some people (women in labor) that, if they're really out of control and they're not doing well, I think they should get an epidural.

Another participant stated:

But, it seems that there's less and less just nice, natural, normal people, too. So many people are high-risk. They have problems. I mean, if they don't have IUGR (intrauterine growth restriction), they have something else or their overdue, or their gestational diabetics, or they've got preeclampsia. I mean, there's very few that come in and have absolutely nothing wrong, really. I mean, it just seems like there's so many different things that go wrong. So, if they're preeclamptic, it's almost like they can't go natural because they'll be so uncomfortable, and their pressures will be so high, and then you can't really let them walk because they're just so limited.

One participant emphatically stated:

I find very few women and their families who actually have faith in the natural process of birth.

Barriers and facilitators supporting NPB. Barriers to supporting NPB were implicit throughout the discussion of factors that influenced the way in which participants were able to provide nursing care to women in labor and birth. For example, one participant maintained that less experienced nurses may not necessarily have the skills to support women in natural birth:

When we orient new nurses, there really isn't a lot of time to have them care for this kind of patient (pt wanting NPB). So what they're taught is focused more on what the routine is that's practiced. And they do go to classes, not childbirth classes -- but I think they do attend a class on the process of normal labor as a part of orientation.

Participants also said that nurses' attitudes about NPB could be a potential barrier to supporting NPB:

Well, all of us can do it (provide care that supports NPB). It's hard for me to be honest and say that they're always going to have somebody who's going to support it. Because it's the next person (nurse) who is up (in terms of patient assignment). It would be nice if all of the people (nurses) would say, "yeah, I'll go take care of that patient, because I know she wants natural childbirth." As a charge nurse, if that patient comes in or if it's a change of shift and I know that the patient doesn't have an epidural, or wants to go natural, I will pick out specific nurses who I know will support them.

When asked why she thought that not all nurses support NPB, the participant replied:

Because they don't know how. Or they just don't have the desire. But I think it's more the desire. It's a lot more work. I think that's why. If you're really doing it right, if you're really being supportive, you can't be out of the room (patient room), like you're not sitting at the nurses' station. But I think people really try for the most part (nurses). You

know, but the other thing is a lot of the physicians are very comfortable with the epidural, and they'll say to the patient, "Well, why aren't you getting it?" I wouldn't say that to someone who really didn't want it.

The following participant expressed another barrier to NPB, which was the excessive use of oxytocin to speed up labor (active management):

So one of the biggest barriers (to NPB) is the routine interventions.

Women come to the labor room with an IV already in place, and there is the incredible use of oxytocin to -- there's almost like a, if you don't move along on our unit, there's something going on. So there's lots of augmentation used.

Facilitators that supported and promoted NPB were also identified. However, participants seemed to be a little more frustrated when they discussed facilitators for the support of NPB. At least half of the participants identified movement in labor as a facilitator for NPB:

I think you (the nurse) just have to see the different things that help make things (labor) move along. Different positions to see how it goes, the best side that's going to move the baby down. That's our ultimate goal. So, sometimes you just try different positions until she wants to push.

A second participant also emphasized movement as a facilitator for NPB:

And if I have someone that really wants to have a natural childbirth, I tell them the key is to move around. It's really hard to get through it if you just sit in the bed or sit in the chair. I think it's very helpful to move

around, not only to get through the pain of natural childbirth, but for helping the labor to move along. I just know it makes a difference.

Another facilitator of NPB was when the nurse advocated for her patient and worked collaboratively with the physician to hold off interventions that would most likely cause stronger more painful contractions. This participant illustrated such an interaction when a physician wanted to do a cervical exam and rupture the laboring woman's membranes:

The thing I like about him (physician) is that I can talk to him. I can say, "You're not checking her. I don't care if it's noontime and you're on lunch, she's not ready to be checked. She's not ready to have her water broken." I mean, "She's not ready for that yet. You can't break her water." She is doing so well. "Why are you breaking her water now? It's too early!" I mean, I don't like it when they break their water. I'm kind of a big one about not doing that, especially when people want to go natural.

Another participant remarked:

When I have a lot of piss and vinegar and I have a lot of fight in me, or I feel like it's really important to this patient to have a vaginal delivery, then I will fight to keep people (providers) away.

Participants also described non-clinical support people as important facilitators to NPB. For example, the following participant recognized the support of doulas when a woman was trying to have NPB:

When I see patients that come in with doulas, I feel like they really benefit. I mean, they (the patient) feel that they need them, they have a relationship, and so having them there is, I think, very helpful for them.

A participant voiced that having supportive people with the laboring woman was associated with better coping and focus.

Some people do very well with their significant other you know, the man. Some men are great, and they really get into it, and they really help the woman focus. But then, I mean, if they're not a ball of fire or very helpful, then they need their mom and their sister, or a friend. And maybe they have two sisters, and I mean, I can't tell them, "You can only choose one." So, I'm pretty lenient about that, people coming in. I think a lot of the time it helps.

In this section the research findings have been presented. Five underlying beliefs emerged from the data. Nurses' beliefs and factors that influence the way in which they provide care to women in labor and birth were also identified. The nurse's desire to establish safety, the affect of the organizational culture on nursing practice, the importance placed on patient satisfaction, and supporting patients in what they want for their birth, were all identified factors.

Discussion

This study explored and described the beliefs of intrapartum nurses about labor and birth. It examined how these beliefs affect the way the nurses provided care to women in labor and birth. The study also examined factors that influenced clinical practice and how the nurses perceived NPB. In the following section, the findings,

which addressed the four research questions, will be discussed. The four research questions were:

1. What is the nature of intrapartum nurses underlying beliefs about childbirth?
2. How were these beliefs initially formed and did they evolve over time? If so, how?
3. How do nurse's beliefs affect the way in which they provide care to women in labor and birth and what factors influence this?
4. What do intrapartum nurses perceive about normal physiologic birth (NPB) and what are the barriers and facilitators for nursing practices that support and promote NPB?

Five underlying beliefs that the participants had about childbirth emerged: (a) childbirth is a profound and empowering event in a woman's life, (b) providing care to women in childbirth is rewarding, (c) women should be supported in their choice for the type of birth that's right for them, (d) a women's satisfaction with the birth experience is important, and (e) intrapartum nurses are experts in the care of women in labor and birth.

The first and second beliefs, childbirth is a profound and empowering event in a woman's life and providing care to women in childbirth is rewarding, were voiced by the majority of participants. Throughout the interviews, the participants described a deep commitment, respect and recognition for the significance of the event of childbirth in a woman's life. At least half of the participants described childbirth as an empowering event for not only the woman giving birth but also for the intrapartum

nurse. Words used by the participants to describe childbirth included spiritual, sacred, and an event with a lifelong influence. It was apparent that all of the participants highly valued this event and considered themselves fortunate to be part of this life experience for women. Participants spoke about the personal gratification of providing care to women in labor and birth, whether it was a birth with a great outcome (healthy mother and baby) or it involved caring for women when the outcome was less than optimal.

The literature is abundant with evidence to support the importance and meaning of childbirth as seen through the eyes of women and their families (Carlton et al., 2009; Davis-Floyd, 2003; Fleming, Smart, & Eide, 2011; Halldorsdottir & Karlsdottir, 1996; Jordan & Davis-Floyd, 1993; Lundgren, 2004; MacKinnon, McIntyre, & Quance, 2005; Nichols, 1996; Rudman, El-Khoury, & Waldenstrom, 2007; Simkin, 1991, 1992). However, there is little available evidence that describes the beliefs of intrapartum nurses about childbirth. An emerging body of literature addresses the effectiveness of nurses as providers of care and labor support, (Bowers, 2002; Hodnett et al., 2002; Miltner, 2002; Sauls, 2007), how nurses view their role, (James et al., 2003) and factors that nurses believe interfere with best nursing practices (Edmonds & Jones, 2012; Sleutel, Schultz, & Wyble, 2007). Findings from this research supported that intrapartum nurses believed that childbirth was a significant event in women's lives.

The findings from one study that explored nurses' perceptions of caring for women in labor and birth were similar to the findings in this research. Carlton et al. (2009) maintained that perinatal nurses heavily influenced women during labor and

birth, but also stated that nurses' voices were noticeably absent in the literature. Carlton and colleagues (2009) interviewed 18 perinatal nurses from four different hospital locations. As a result of the interviews, four important themes emerged. The first theme was the rewards for caring for women in labor and birth are many. Second, barriers were identified that negatively influenced supportive nursing care. Third, there was a difference in caring for women who were medicated versus unmedicated, and last, nurses had an aversion to written birth plans. The four themes identified by Carlton et al. (2009) had a surprising similarity to the findings from this study. This perhaps gives voice to intrapartum nurses and may begin a dialogue about the meaning and beliefs of childbirth to nurses in this specialty.

In this study, the third belief that emerged was that women should be supported in their choice for birth. Not surprising, this was discussed by all the participants, especially when discussing a medicalized birth versus a NPB. Participants were adamant that it was a woman's choice for the kind of birth she envisioned for herself, and whatever she chose, she should be supported in that choice. This belief placed the woman in labor at the center of care. Participants believed that advocating for women and their choice was fundamental in providing intrapartum nursing care. The central tenets to this belief included listening to what women want, understanding what their hopes were for birth, distinguishing who their support people were and identifying the kind of childbirth preparation. As one participant pointed out, this belief undergirded the critical attributes of what it meant to be a caring and empathetic nurse: the provision of non-judgmental, empathetic, compassionate and sensitive care. Belief number three was central to the art of caring in professional nursing practice. The

American Association of Colleges of Nursing (1998) supports the essence of nursing care which, “. . . Encompasses the nurse’s empathy for and connection with the patient, as well as the ability to translate these affective characteristics into compassionate, sensitive, appropriate care” (AACN, 1998, p. 8).

All of the participants in this study believed that intrapartum nurses should honor the woman’s plan for birth. However, similar to findings in Carlton’s study (2009), not all participants were supportive of a written birth plan. Some nurses viewed the written birth plan as too formal and at times unrealistic. The majority of participants expressed an appreciation for women who verbalized their birth plan, and one participant emphasized how difficult it was when a patient comes in with no plan at all. While all of the participants spoke about the importance of honoring the birth plan, several factors and sub-beliefs emerged that appeared to challenge this belief.

The nurses’ perception of their responsibility to establish safety was the most important factor affecting the way in which they provided care to women in labor and birth. The safety factor significantly influenced the participant’s third belief; that women should be supported in their choice for the type of birth they planned for.

Several participants emphasized the importance of supporting women’s choices, as long as everything remained in the realm of safety. The word safety referred to the ability of the intrapartum nurse to critically assess maternal/fetal well-being. Establishing safety meant the use of EFM.

There were many factors that influenced the nurse’s ability to establish safety. Individual judgment, experiential knowledge, and influences from the culture of the birthing unit each generate a subjective approach to establishing safety. Along with

personal experience and professional judgment, the establishment of safety almost always required the use of various forms of technology and some technological methods are more intrusive than others. The medical model of birth has created a maternity system that relies heavily on the use of technology to establish maternal/fetal safety. This clinical practice is not just limited to women with risk factors, but is also used with normal, healthy childbearing women (Goer & Romano, 2012; Romano & Lothian, 2008).

So, while all of the participants spoke about the importance of patient centered care, more than half of the participants emphasized safety first, which in this culture was associated with the use of EFM and/or continuous EFM. EFM can potentially interfere with walking and staying active in early labor. Additionally, it can interfere with hydrotherapy (shower or Jacuzzi) and other non-pharmacologic methods used for pain relief that have been shown to support labor progress and NPB (Goer & Romano, 2012).

Establishing safety primarily by the use of EFM suggested two important findings for this research. First, was the underlying mistrust of childbirth as a safe and healthy experience in a woman's life? Regan and Liaschenko (2007) found that labor and delivery nurses viewed birth in three ways. Birth was either a natural process, a risky process, or an event with a lurking risk. The intrapartum nurses in this study believed that their practice of using EFM to establish safety was a priority. The nurse first confirmed safety, and then would consider the patient's birth plan. Nurses practicing on this particular birth unit cognitively framed childbirth as an event always with a potential for risk.

One participant pointed out that “we” (implying herself and her nursing colleagues) don’t categorize women who are admitted to the birth unit as low risk or high risk. She explained that generally, all women were “lumped” together, and the majority of care was routinized. This comment had great significance. According to Stapleton, Osborne and Illuzzi (2013), 85% of women in labor are low risk on admission to the hospital. Continuous EFM, an intervention that is typically used for women with high-risk conditions, has not been shown to make a difference in outcomes for low-risk women, and has been shown to potentially cause harm (Simkin & O’Hara, 2002). Romano and Lothian (2008) assert that there are specific nursing care practices to support low-risk women in NPB. Grouping all women together, especially in a maternity setting that is philosophically grounded in the medical model of care, creates a labor and birth environment that exposes the majority of women to the use of unnecessary interventions. While participants told stories about the satisfaction of caring for women experiencing NPB, it was the exceptional experience rather than the typical.

A second study finding related to safety and the use of EFM was the participants’ alignment with the medical model of birth. Almost all of the participants were aware that the use of continuous EFM did not improve maternal/fetal outcomes for low-risk women (Alfirevic, Devane, & Gyte, 2013; Devane et al., 2012), yet they routinely used EFM on all their clients, low or high risk.

Miltner (2000) surveyed 186 members from AWHONN and found that the members believed the overall goal of intrapartum nursing was to assure a safe outcome for mother and newborn. Returning to the belief that women should be supported in

their choices for birth, the use of EFM to establish maternal/fetal safety could be in conflict with a woman's birth plan, especially if the woman desired to avoid unnecessary intervention. The participants acknowledged a woman's birth plan but only supported it when aligned with the usual care in the maternity care setting.

Establishing safety was the most important underlying factor that influenced nursing care. While the safety and well-being of the mother and fetus couldn't be minimized, the process of establishing safety with EFM and the accompanying restriction of movement associated with this approach supported the medical model of care, not NPB.

Belief number four focused on the importance of women's satisfaction with their birth experience. For many participants, a woman's satisfaction with her birth experience influenced the nurse's perception of the quality of nursing care provided. At least half of the participants made statements that, if the woman was happy after her birth and she and the baby were healthy, then that was what was most important. One participant stated:

And at the end of the delivery, the mother and baby are safe, and the woman got an experience she hoped for, and she feels good about it, that's what makes me tick. That's the best part of the day. A happy healthy Mom and a happy, healthy baby, no matter which way it (they) got here, but according to Mom's plan.

By specifically pointing out that this was the 'best part of the day', the participant linked the safety, the actualization of the mother's birth plan, and maternal satisfaction with her own belief that providing care to women during childbirth was rewarding.

Overall, this quote summarized beliefs one through four and also highlighted the significance of safety for maternal/fetal well-being.

At least half of the participants associated the quality of their nursing care with the woman's satisfaction with her birth. In other words, when the mother was happy, the nurse was happy, and felt as if her nursing care was successful and valued.

However, throughout many of the interviews there were nuances to this belief.

Returning to the quote above, consider the phrase, "no matter which way it (women in labor and birth) got here." The participant highlighted the outcome, and minimized the processes of birth. There was no question that a healthy outcome for the mother and baby was at the forefront. Nevertheless, when the sole emphasis was on outcomes as an ultimate goal of measurement, the process of achieving the outcome became marginalized.

The importance of labor support provided by nurses has been documented in the literature (Corbett & Callister, 2000; Miltner, 2002; Hallolorsdottir & Karlsdottir, 1996; Sauls, 2006). Women have reported satisfaction with their birth when nurses spend time with them, provide comfort, reassurance, showed concern, and provided explanation. All of these nursing actions contribute to maternal satisfaction with childbirth (Corbett & Callister, 2000). Hallolorsdottir and Karlsdottir (1996) concluded that caring behaviors shown to the women in labor was associated with empowerment, while non-caring behaviors correlated with maternal feelings of discouragement. While the acknowledgement and understanding of the patient's birth plan was an essential aspect of quality nursing practice, nurses must also recognize that not all women are informed of the best evidence supporting labor and birth. With the increase

in the rate of cesarean delivery, unnecessary induction of labor, and low breastfeeding rates, it is essential for nurses to acknowledge the critical responsibility they have to educate, support, and provide guidance to women concerning best evidence-based practices. Miltner (2002) concluded that the processes of supportive nursing care was linked with improved childbirth outcomes. While many of the participants in this study maintained a belief in the importance of women's satisfaction with her birth, a caution was recommended to avoid emphasis on the outcome above the emotional support of the processes.

There is a body of literature on posttraumatic stress disorder (PTSD) related to birth trauma (Beck, 2004; Beck, 2006; Beck & Watson, 2010). Beck, (2004) analyzed the birth stories of women who were identified as having PTSD. One of the four emerging themes was the discussion of, if the end justifies the means and at whose expense? Recognition that the process of childbirth is equally as important to the outcome is essential.

Participants linked belief number five; intrapartum nurses are experts in the care of women in labor and birth with the sub-belief that expert nursing care can positively influence maternal/fetal outcomes. Because nurses spend the most time with women in childbirth, they are well positioned to influence outcomes (Corbett & Callister, 2000; Edmond & Jones, 2013; James et al., 2003; Kennedy, 2010; Sauls, 2007). Kennedy and Lyndon (2008) state, "nurses are the frontline providers of birth care in the U.S. for most women. . . . because of their sheer numbers, (they) probably hold the greatest potential to influence the culture of birth in the U.S." (p. 435). The majority of participants revealed that their expertise was to establish maternal/fetal

well-being, advocate for the patient, and provide assistance in decision-making about pain management options. Several participants also associated expert intrapartum nursing care with helping to optimize vaginal birth (i.e. helping women change positions in labor), labor support, and establishing a sense of safety and security in situations that might be frightening for the woman.

Benner, Tanner, and Chesla (2009) maintain that in order to become an expert nurse, an experiential base within a particular patient population is required. Once an expertise in nursing practice is developed, nurses are able to develop a highly skilled clinical mastery in their specialty area. Benner et al. also maintains nurses must also connect with patients on an individual basis and recognize the unique relevance for what is most important in a given situation. The majority of participants in this study believed the greatest potential to positively influence the birth experience was when a woman worked collaboratively with them by accepting their recommendations and responding to their guidance and suggestions. All of the participants in this study had many years of experience on this birth unit. They had obtained an experienced-based, practical knowledge specifically in the care of women in labor and birth, primarily in an environment supported by interventions and use of technology. Several participants discussed what happened when a woman was unprepared for the rigors of labor and birth and was resistant to working with the intrapartum nurse. When this scenario occurred, the majority of participants suggested a medical model approach was most likely. This often included an early first stage epidural which was often followed by a cascade of interventions.

The previous discussion provides a more in-depth understanding to how nurses' beliefs support or challenge the way in which they provide care to women in labor and birth. Participants also identified many factors that affected the way in which intrapartum nurses provide care for women. The three most significant categories were the woman in labor and birth, the organizational culture and NPB.

The woman in labor and birth. Twenge (2006) asserts that the generation a person is part of as a child molds them for the rest of their lives. Individuals born in the mid-1970s, 1980s and 1990s are today's generation of childbearing women. Twenge terms this generation as the *Me Generation*, characterized as self-focused, self-important and optimistic, although often times unrealistic. Young people have been taught to meet their own needs first and to think highly of themselves. Most individuals in this generation have been raised in an on demand culture, with things readily available to them such as the Internet, cable TV, cell phones, microwaves and fast food. There is an endless stream of instant gratification at their fingertips.

At some point in every interview, participants expressed that the childbearing culture of today was different from years ago. Today's women were perceived as largely unprepared and unmotivated for the rigors of labor and birth. Overall, the participants perceived today's generation of childbearing women to be less healthy and less physically fit than previous generations. Additionally, this generation of women was more likely to request an elective induction of labor for their convenience.

All of the participants spoke about the use of the epidural for pain relief by women in this generation. While the majority of participants believed that women were not as prepared for childbirth as they used to be, more than half of the participants

made statements to support that many women today didn't want to experience 'natural birth'. Several participants suggested that the availability of the epidural at their institution had contributed to women's lack of preparation for childbirth: "*The women came in asking, 'How soon can I have my epidural?' They might not know how to speak English but they know the word epidural.*"

Almost all participants pointed out that this generation of women were learning about childbirth differently than the generation before them. This generation watched reality TV, surfed the Internet, and listened to the advice from friends and family. All of the participants spoke about childbirth education classes and how attendance was dropping. Consequently, women were coming to the labor unit with unrealistic expectations of how long it took to have a baby and how much work it involved. The majority of participants believed that in order to be successful at NPB, a woman must be healthy, motivated, and prepared for the hard work of labor and birth.

In the U.S., the declining trend in women's participation in childbirth education, correlates with the increase in the rates of cesarean delivery and induction of labor (Lothian, 2008). Lothian's findings confirm the participants observations that over the last decade women have turned away from childbirth education classes and are now accessing information on the Internet and television. Lothian (2008, 2009) findings and the results from this study support that childbirth has become medically interventive-intensive. Lothian (2009) states, "It is safe to say that we are experiencing a crisis in maternity care in the United States. We are also experiencing a crisis in childbirth education" (p. 46). The author points out that while childbirth education was founded on the tenant of respect for women's choice, educators in the last decade have

become too complacent about supporting women's decisions for childbirth, as many women now are choosing the medical model for birth (Lothian, 2008). The author recommends a need to return to a place where childbirth education revolves around presenting the best evidence to women and families. This will help to support and instill confidence in women to trust in birth in a healthy, non-interventive way.

Lothian's recommendation resounds with the study participants' beliefs and the importance of supporting women and their choice for birth. The underlying question becomes whether women should be unconditionally supported when their choices are very often mired in a perception of birth that involves quick fixes and technology to reach the end result, birth.

Declercq, Sakala, Corry, and Applebaum (2006), and Lothian (2007) suggest there is some evidence to support that there is no difference in birth outcomes for women who have or have not attended childbirth education classes. One possible explanation for this is the current structure of childbirth education. Many childbirth education classes are taught in the hospital where women are planning to give birth. The hospital employs the educators. It is possible that class content is focused more on options for birth at a particular institution. Hospital classes are more affordable, thus the majority of women who actually take the classes do so through the hospital, in a big class, that meets once, for a full day. The classes are informational sessions about birth in the particular organization. This is in contrast to disseminating knowledge about methods to assist pregnant women in labor and birth, based on the best evidence for a healthy outcome for mother and newborn. Zwelling (2008) suggests that an

unfortunate result of the availability of epidural anesthesia in many maternity care settings is that many parents believe that childbirth education classes are unnecessary.

Supporting the participants' belief that many women who were admitted to the birthing unit were poorly prepared for childbirth allowed no puzzling over why the medical model of birth was the dominating model of care on this particular birthing unit. Whether it was the overall comfort with technology, the availability of epidural anesthesia, the characteristics of the new generation of women in today's culture, or the need to develop new ways to get information out to new parents, almost all of the participants believed that today's generation of childbearing women were not consistently prepared for childbirth. There is evidence to support participation in childbirth education has dropped. Findings from this study are consistent with the evidence, and are especially relevant coming from the health care professionals who provide the majority of intrapartum care.

More than half of the participants remarked on the increase in high-risk pregnancies associated with the rise in obesity and associated co-morbidities in the U.S. over the last two decades. Findings from this research study were consistent with the current literature. Morin and Reilly (2007) assert that obesity rates have increased considerably over the last 20 years. Walsh (2007) supports that obesity is a worldwide epidemic. This directly correlates obesity with the increase in preeclampsia among today's young pregnant women. Wallis, Saftlas, Hsia, and Atrash (2008) looked at trends in preeclampsia from 1987 to 2004 and concluded that, over the seven-year period, the rates of preeclampsia have increased by 22%. Getahun, Nath, Ananth, Chavez, and Smulian (2007) looked at trends in gestational diabetes (GDM) from 1989

through 2004. These findings showed the prevalence rates of GDM in the U.S. have dramatically increased (an increase of 122%). Sathyapalan, Mellor, and Atkin (2010) claim that the prevalence of GDM is increasing worldwide, affecting approximately 7% of all pregnancies. The authors' state that the presence of obesity has had a significant impact on the maternal/fetal complications associated with GDM.

The majority of participants identified an increase in obesity and associated comorbidities in the current generation of childbearing women. These two factors affected nursing care in the maternity setting. High-risk pregnancies increased the use of medical interventions and use of technology. The upward trends in preeclampsia and GDM increased the number of women who are at high-risk. These patients require the use of more technology and the accompanying skilled nursing care (Morin & Reilly, 2007). Obese women in labor and birth are at an increased risk for induction of labor, cesarean delivery, failed trial of labor after cesarean, postpartum infection and decreased rates of breastfeeding. A change in the physical environment to accommodate obese women in labor and birth is needed. Difficulties establishing maternal/fetal status and the challenges in providing post-operative care are significant factors affecting nursing care in today's maternity care setting (Morin & Reilly, 2007). The participants' discussion was consistent with the findings in the literature. There is significant evidence in medical literature on the risks associated with obesity and pregnancy. However, the literature on obesity, high-risk pregnancy, and the impacts on intrapartum nursing care practices are sparse. Findings from this study highlight the need for maternity care hospitals to further explore factors affecting the nursing care of obese women in labor and birth.

More than half of the participants discussed the rate of induction of labor with the new generation of childbearing women, for both medical reasons and life style preferences. Participants reported that nursing practices were more technology focused when women were being induced. Several participants believed that pregnant women and obstetricians both had a stake in the rate of elective induction. One participant claimed that many women wanted to have their labor electively induced because they were physically uncomfortable, tired of waiting, and it was more convenient for the pregnant woman and at times her obstetrician. The rate of induction of labor has increased nationwide over the last decade (Zhang et al., 2010). Zhang and colleagues analyzed 230,000 electronic medical records from 19 hospitals across the U.S. between 2002 and 2008 and found the induction rate was 44% in women who were planning a vaginal birth. Elective induction of labor before 39 weeks gestation has become a public health concern. Organizations such as the March of Dimes (www.marchofdimes.com) and AWHONN have campaigned to “Go the Full Forty”; (www.awhonn.org/awhonn/). However, the induction rate at the participants’ institution remained high and had a significant impact on intrapartum nursing practice.

All participants in this study believed that the characteristics of today’s generation of childbearing women influenced intrapartum nursing care. Whether or not it was women lacking the fortitude to endure the pain, the high rate of epidurals, the decreasing rate of childbirth education, the high risk co-morbidities associated with obesity, or the rate of labor induction, all of these factors were identified by participants as influential factors affecting nursing care. This was a significant finding. While the sociology literature supports the specific characteristics of this generation of

women, linking these characteristics to how it affects the nursing care of women in childbirth has not been reported in the literature.

Organizational factors affecting nursing care. For the participants, organizational factors played a significant role and influenced intrapartum nursing care. Will, Hennieke, Jacobs, O'Neill, and Raab (2005) looked at the role the intrapartum nurses play in the safety and quality of care for mothers and newborns. This was examined because medical malpractice claims, settlements and jury awards are the highest they have ever been.

The standard of care on the participants' birthing unit is continuous EFM, and while the evidence does not support this practice for low-risk women, it is still widely practiced. Continuous EFM is associated with safety, a protective measure against medical malpractice claims and requires adequate nursing coverage for the high patient census. The participants suggested that EFM required a ratio of two patients to one nurse, which was especially beneficial to the organization when staffing patterns were unpredictable. The technological savviness required to manage the demands of electronic documentation, the machinery associated with EFM and other interventions while providing quality patient care was a great challenge for the nurses. Unfortunately, this affects women who would like to achieve NPB. NPB requires one-on-one hands on nursing care. At least two participants stated that they have had to make choices between patient care and electronic documentation. Both participants maintained that their electronic documentation was monitored by administration and if left incomplete, the administrative leaders would frown upon it. While almost all of the participants discussed the difficulties associated with balancing electronic

documentation with patient care, the Institute of Medicine (www.iom.edu) recommends a switch from paper documentation to electronic documentation for all health care providers over the next few years. Failure to comply may lead to penalties imposed on hospital organizations. (Kelley, Brandon, & Docherty, 2011). Unfortunately, this type of documentation is becoming standard across US hospitals without evaluating the impact on nursing care (Kelley et al., 2011). The majority of participants in this study reported that the process of electronic documentation is time consuming and overwhelming and it doesn't necessarily reflect what nurses actually do. Ammenwerth, Mansmann, Iller, and Eichstadter (2003) suggest that traditionally, the process of nursing documentation (paper documentation) has been an important tool for critical thinking and reflection on the nurses' plan of care. While electronic documentation may be a time saver for nurses, this form of documentation may affect a nurse's critical thinking skills. A systematic review examining electronic nursing documentation in the hospital setting (Kelley et al.) suggests future research is necessary to determine the impact of electronic documentation on the quality of nursing care.

The unpredictable relationship with attending physicians was a theme throughout many of the interviews. Several participants spoke about efforts being made to improve the nurse-physician relationship but other participants believed things were not improving. The participants believed they were experts in intrapartum care, and that their input was important and essential to the quality of patient care. However, the acknowledgement of nurses as experts in the care of women in childbirth was often underappreciated on the labor unit. The nurse-physician relationship was tentative and

fueled mistrust. Some study participants discussed a tendency to work around the physicians using *subtle defiance*. Rather than engage in a professional conversation with the physician, the expert nurse would *subtly* do things her way, behind the scenes in order to support a patient's plan of care. The nurse appeared to be conforming to the physician's management decisions but unintentionally perpetuated the traditional authoritative hierarchies between medicine and nursing. When nursing actions were carried out by subtle defiance, the perception of the 'intrapartum nurse as an expert' by other members of the health care team is also jeopardized. Edmonds and Jones (2012) suggest that negotiating successfully with physicians is a necessary skill for the expert nurse, acquired through experience. The findings from this study were not supportive of Edmonds and Jones. While all of the participants had many years of experience in intrapartum nursing care, the ability to negotiate patient care with physicians was inconsistent. Several participants discussed that negotiation with physicians was time consuming and took a lot of effort. Subtle defiance seemed to be preferable for this study population. Several participants told stories where they were able to help a woman experience the process of NPB by using subtle defiance and pleasant banter with the physician to "keep them out of the room."

Over the last two decades, the culture of birth has been significantly reshaped by the medicalization of childbirth. The medical model of birth underlies the culture of care in the organization where the participants in this study practiced nursing. Three examples of the medical model of birth were apparent. First, the vast majority of participants consistently described women in labor and birth as a *patient*, a word that generally refers to an individual who is sick, suffering or under medical treatment

(Imrie, 1994). This is in contrast to referring to the woman as a *client*, an emerging term used for women in labor, as it implies the care of someone who is under the protection of another, or engages the professional advice or services of another (Miriam Webster On-Line Dictionary, retrieved February 2, 2014). A second example suggested the traditional hierarchy of the patriarchal physician- nurse relationship existed in this maternity setting. While participants consistently recognized the importance of advocating for women and supporting their birth plan, at least half of the participants reported that they believed the physician has the final word in decision-making and management. Several participants described situations where they would challenge the physician's decision, but only in special circumstances. The third example of the medicalized environment is the high rate of epidural anesthesia (consistently over 75%). Conversations throughout the interviews often focused on the difference between caring for a patient with an epidural or without. It was common for participants to described NPB as a woman in labor without an epidural. All of the participants discussed issues around how they supported women in decision making about whether or not to have an epidural. There was very little discussion of nursing care in between the dichotomy of epidural or no epidural. For example, there was no discussion of offering Morphine or other pharmacological analgesics used for pain management in labor.

Because the intervention rate was so high in the setting where the participants practiced nursing, the intrapartum nurse's role was very challenging. The majority of the participants discussed the challenges of caring for women in today's culture of technology dominated maternity care. The literature supports that best nursing practice

for many intrapartum nurses involves well-developed interpersonal skills, complex maternal-fetal assessment skills, and technical proficiency (Carlton et al., 2009; Downe, Simpson, & Trafford; 2007; Hodnett, 1996; Miltner, 2000; Payant et al., 2008). While beliefs about childbirth emerged as findings in this study, factors that affected nursing care often sidelined these underlying beliefs.

Normal physiologic birth. Participants' perceptions about NPB were revealed through the storytelling and conversations during the interview. Descriptions of best birth scenarios indicated that the majority of nurses did embrace the evidence that NPB was a safe and satisfying way for childbearing women to experience birth (Downe, 2008; Romano & Lothian, 2008).

The majority of participants believed that most women seeking care at their institution had a minimal interest in experiencing NPB. Participants attributed this to the characteristics of today's generation of childbearing women, the overall lack of preparation and an unrealistic expectation for the work involved during labor and birth. Participants also discussed the cultural norms of the birth unit, which were dominated by the medical model. The availability of epidural anesthesia and the potential cascade of interventions that followed, the nurse's underlying fears of medical malpractice, unpredictable staffing patterns, the difficulties of balancing the demands of electronic documentation and adherence to routine patient care all contributed to the maternity care culture that the participants practiced in. Last, the majority of the participants believed that most physicians do not see the benefits of NPB.

Building on Lamaze International's Healthy Birth Practices (2003), Romano and Lothian (2008) provided evidence for six *nursing care practices* that were

evidence- based to support the processes and safe outcomes associated with NPB. Prior to the end of each interview, the six care practices were shared with each participant. None of the participants were familiar with the Lamaze International six care practice recommendations, or the Romano and Lothian article, however, all of the participants were very interested and several participants asked for a copy of the article.

The six care practices focus on evidence to support specific nursing practices that promote and support NPB. The nurse's role in supporting and encouraging the spontaneous onset of labor, the importance of encouraging freedom of movement in labor, and continuous labor support, are three of the six practices emphasized. The other three practices focus on the avoidance of routine interventions, the importance of encouraging spontaneous pushing in non-supine positions, and the benefits of skin-to-skin and early breastfeeding within the first hour after birth (Romano & Lothian, 2008). In order to provide a little structure to the discussion for this part of the interview, participants were asked if they felt the six care practices were realistic in their hospital setting. The following section includes discussion on the participant's perceptions of NPB, particularly as they related to Romano and Lothian's recommendations for practice.

The 1st Care Practice. All of the participants agreed that the spontaneous onset of labor was better for women in childbirth. Several participants made reference to how nice it would be not to have to care for so many women having lengthy labor inductions and the high tech interventions required with labor induction. At least half of the participants supported what is in the literature. Inductions of labor can be a long process and most of the time it can start a cascade of interventions, potentially placing

the woman at risk for a cesarean delivery, especially if the mother is primiparous (Carlton et al., 2009; Ehrenthal, Jiang, & Strobino, 2010). The researcher asked at least half of the participants if they questioned the medical provider's decision to electively induce a woman's labor, especially when they realized the circumstances didn't support best evidence. Several of the participants that responded believed that by the time they met the patient, (on admission), the patient had already developed a plan with her physician, and it became awkward to interfere with their plan.

The 2nd Care Practice. Freedom of movement was unanimously described as an important step in promoting NPB, especially in early labor. Many of the participants told stories illustrating how they promoted movement and ambulation in early labor. There is sufficient literature to support the importance of freedom to move in labor (Declercq, 2013, 2006; Goer & Romano, 2012; Romano & Lothian; 2008; Simkin & O'Hara, 2002). While most of the women in this birth setting requested epidurals, the participants' discussion was primarily focused on the use of movement in relation to early labor. However, all of the participants recognized the importance of movement if a woman wants to have a NPB.

The 3rd Care Practice. Continuous labor support (CLS) is well documented in the literature as beneficial for all women in labor and birth, and especially for women who seek NPB (Hodnett et al., 2007, Hodnett et al., 2002; Simkin & O'Hara, 2002). All of the participants acknowledged that due to the patient census and unpredictable staffing patterns, they could not be guaranteed to provide one to one nursing care, and there was recognition that CLS was an essential part of the process of NPB. Most of the participants made reference to the importance of support person (s)

with women in labor. There is good evidence linking CLS in labor with optimal outcomes for women and newborns (Hodnett et al., 2007). The literature supports the benefit of doulas as labor support companions (Ballen & Fulcher, 2006). Ballen and Fulcher 2006 assert that evidence has been shown to support that doula care is associated with improved childbirth outcomes. They suggest that doula care can be complementary to intrapartum nursing care, and should be an option for all women giving birth. The participant's view of the helpfulness of the doula in providing labor support was varied. One participant stated she appreciated a doula's support for women in labor, while two participants stated they did not like it when doulas were present at birth. They implied there was role confusion between the nurse and the doula. One participant stated that she believed that the nurse is forced into an authoritative state when a doula is present.

The 4th Care Practice. The challenge with the fourth practice, no routine interventions, was an underlying theme addressed throughout the study. The evidence is consistent in the literature to support that routine use of interventions is unnecessary in low risk pregnancies. The participants acknowledged that the model of care in their institution was based on the medical model and most women were not being encouraged to prepare for NPB in the prenatal period. At least half of the participants expressed that by the time women reach the labor unit; it is often too late to start educating women on the benefits of NPB. They suggested that obstetrical care providers and childbirth educators should emphasize and discuss the benefits of NPB throughout the prenatal period. Results from *The Listening to Mothers III* survey

(Declercq et al., 2013) suggest that routine interventions are still very much a part of maternity care practice in the U.S.

The 5th Care Practice. All participants believed that practice number five, pushing in non-supine position was best practice and many told stories of how they encouraged women to push on their side or semi-upright positions. This was a challenge within an organizational culture of high rates of epidurals and women's restriction to bed. Participants also discussed that attending physicians preferred women to be in the traditional lithotomy position for birth. One participant stated that she would have women push on all fours if they could, or lean forward with the support of a bar across the bed. However, just before the physician arrived for the delivery, she was careful to get the woman back to the supine position prior to them entering the room. This was an example of the subtle defiance that many nurses used to promote best practices.

The 6th Care Practice. The majority of participants' supported the importance of the sixth care practice, no separation of mother and baby. However, one participant discussed the difficulties with this practice when multiple family members were present in the room post-delivery. This participant believed that the presence of family sometimes interfered with establishing initial breast-feeding and the promotion of skin-to-skin contact.

The majority of the participants believed that in order for women to be successful at NPB, there were three factors that most influenced success. Participants believed that women must be physically healthy, because it takes endurance and fortitude to accomplish NPB. They must be motivated to endure the sometimes long

and difficult process of an unmedicated birth and they must be prepared, either formally or through some other means of learning about childbirth (for some women it might be the experience of having already given birth). When these factors aligned, participants believed that not only was it possible for women to achieve NPB, but the intrapartum nurse was more willing to support her.

In conclusion, the contribution to nursing knowledge from this research study was in the domain of nursing practice. Central to intrapartum nursing practice was the way in which the nurses provided care to women in labor and birth. Findings supported that participants perceived the establishment of safety for mother and baby was a top priority for intrapartum nursing care. The underlying medical model of care influenced how safety was established. The organizational culture also had many factors that influenced nursing practice.

Two of the five beliefs (patient satisfaction and patient characteristics) emerged as significant findings. Patient satisfaction with their birth experience emerged as a belief that held significant importance for the participants, and tied into how nurses viewed the quality of the care they provided. Several of the participants associated patient satisfaction solely with the outcome of a happy, healthy mother and baby, unknowingly undervaluing the processes of labor and birth. The support for women and their birth plan also emerged as a significant belief. However characteristics of the new generation of childbearing women presented challenges to how this belief affected the way in which intrapartum nurses provided care. The literature supports the importance of a woman's positive and satisfying experience with her birth (Bowers, 2002; Corbett & Callister, 2000; Halldorsdottir & Karlsdottir, 1996). However, Gee and

Cory (2012) caution that not all women have adequate knowledge to make the best choices, and suggest that patient education should be a major focus to assist women in making informed decisions about their care. At least half of the participants discussed that education and preparation for labor, birth and breastfeeding should begin early on in the prenatal period, and suggested that physicians take more of an active role in patient education. A couple of study participants recommended that physicians (and midwives) begin discussions to promote the benefits of NPB right from the beginning of the pregnancy. While the other three beliefs, childbirth is a profound event in a woman's life, providing care to women in labor and birth is rewarding, and intrapartum nurses are experts in the care of women in childbirth, emerged from the research data, participants were more readily influenced by safety, organizational factors, the importance of patient satisfaction and patient choices.

Chapter V

Summary, Conclusion, Limitations and Implications

This chapter summarizes the research study. Conclusions, limitations and implications will all be discussed.

Summary

Childbirth is an important and significant event for women across all cultures. Birth is a uniquely individualized experience for women, and can be an empowering, life-changing event, especially in the transition to motherhood. Childbirth is a healthy, normal event for the majority of women in the world; however, normal birth is not usual for many women in the U.S.

There are two opposing views of childbirth in the U.S., the medical model and normal physiologic birth model. The medical model relies on technology and intervention to assist women through labor and birth. It is the dominant paradigm of obstetrical care in the U.S. The NPB model, also known as normal birth and physiologic birth, promotes childbirth as a normal healthy event in a woman's life. The vast majority of women are innately capable of physiologic birth in the U.S. and across the world.

In the U.S. approximately 99% of births take place in a hospital setting. The medical model of care has dominated the hospital setting for the last two to three decades. Childbirth has become an interventive-intensive experience for women, involving the routine use of technology and intervention. The practice of interventive obstetrics is not supported by best evidence and, potentially places many women and newborns at risk for increased rates of morbidity and mortality.

The medical model of care places less emphasis on the *processes* of birth and more significance on the *outcome* of the healthy mother and baby. While there is no debate that healthy maternal/newborn outcomes are important to all involved, when outcomes are the priority, human presence, spiritual, psychological, and social support become marginalized.

The cesarean delivery rate of 32.8% is the highest it has ever been in the U.S. The prevalence of other interventions during childbirth is high as well. The excessive use of epidural anesthesia, continuous EFM, elective inductions of labor and use of oxytocin to augment labor are all examples of interventions that childbearing women today are exposed to. There is insufficient evidence to support the practice of routine intervention(s) for women who are at low risk for complications in pregnancy and childbirth. The view of childbirth as a healthy, normal event in a woman's life has been replaced by a maternity care system that routinely interferes with the normal, physiologic process of birth. By doing so, the mother and baby are potentially introduced to unnecessary risks.

While all of this technology and intervention is perceived as essential in the culture of obstetrical care, maternal/fetal outcomes have not significantly improved over the last quarter of century. While there has been a slight decline in the infant mortality rate for the U.S., the rate remains higher than most other developed countries. Presently the U.S. ranks 30th in the world. The maternal mortality rates also remain high compared to other developed countries.

While technological advances in medicine and obstetrics have been shown to improve outcomes for women with high-risk conditions, the majority of women

admitted to health care facilities for labor and birth in the U.S. are at low risk for complications. Maternity care in the U.S. has become a system designed to care for all women as if they are at risk for complications and poor outcomes. This instills an underlying fear in not only childbearing women, but also in the healthcare providers that provide care to women and their families during childbirth.

Because most births take place in a hospital setting in the U.S., the frontline providers of care are intrapartum nurses. They spend more time with women in childbirth than any other health care professional. They are in a key position to improve the quality of care that is urgently needed in the U.S. maternity care system.

Due to their sheer numbers and consistent presence with women and newborns in labor and birth, it is important to understand nurse's beliefs and perceptions about childbirth. Nurses' valuable insight and recommendations on the important issues facing the delivery of maternity health care in the U.S. needs to be acknowledged.

The purpose of this descriptive, qualitative study was to explore intrapartum nurses' beliefs about childbirth. Its specific aim was to identify and describe the nature of intrapartum nurses beliefs, how these beliefs affect the way in which they provide nursing care, and what factors influence their clinical practice. The secondary aim of this study was to examine nurses' perceptions about normal physiologic birth, and factors that support and hinder NPB practices.

A descriptive exploratory design was chosen as the method of research for this qualitative study. Ten experienced intrapartum nurses were recruited, using a snowball sampling plan, for the study. All of the participants practiced at the same institution, an

academic, tertiary care hospital specifically for women and newborns. The study was designed to address the following four research questions:

1. What is the nature of intrapartum nurses underlying beliefs about labor and birth?
2. How were these beliefs initially formed and did they evolve over time? If so how?
3. To what extent do intrapartum nurse's think that their beliefs affect the way in which they provide care to women in labor and birth, and what factors influence this?
4. What do intrapartum nurses perceive about normal physiologic birth and what are the barriers and facilitators for nursing practices that support and promote normal physiologic birth?

Quantitative research methods would not have yielded the depth and richness of detail included in the final data. Through interviews, storytelling and conversation, the researcher was able to develop a deeper understanding of the beliefs, perceptions and factors that influence intrapartum nursing practice for the care of women in labor and birth. Participants seemed very willing to reflect on their nursing practice through guided conversation and storytelling.

A review of literature provided evidence to support how the medicalization of childbirth presents obstacles and potential risks for childbearing women in our current maternity care system. The literature also supported the need to reemphasize childbirth as a normal physiological experience for childbearing women. Many of these professionals also provided suggestions and guidelines for pathways to improvement.

The contributions to the literature on the importance of NPB by physicians and obstetricians remain sparse.

The 2013 results of the recently released *Listening to Mothers III* survey provides evidence to support that routine use of intervention in the U.S. maternity care system continues to be the dominant model for maternity care. The most recent released data from the Center for Disease Control (CDC) Division of National Vital Statistics Birth Data (2012) also provides current information on the rising number of cesarean deliveries performed in the U.S. This evidence is critical, as cesarean delivery is becoming more acceptable as the normal way to give birth.

The definitions for NPB vary between organizations and individuals. While the definitions differ, most definitions originate from the WHO document *Care in Normal Birth: A Practical Guide* (1996). For example, some of the organization's definitions include the use of synthetic oxytocin in their definition of NPB while others reject the use but include the use of epidural anesthesia in NPB. The ACNM consensus statement (2102) rejects most interventions, provides a comprehensive definition of physiologic birth and identifies benchmarks to describe the optimal processes of birth. The most prominent obstetrician and professional nursing organizations both lack formal statements for the support and promotion of NPB.

Current methods of evaluation and measurement related to outcomes for childbirth is primarily concerned with poor outcomes. Morbidity and mortality rates, inductions of labor, operative deliveries, low Apgar scores and postpartum complications are some of the parameters that are measured in our nations maternity health care system. This is in contrast to measuring the outcomes associated with

childbirth, such as successful vaginal delivery, early hospital discharge by choice and successful breastfeeding rates. Murphy and Fullerton (2006) propose a unique, innovative instrument to measure the quality of maternity care termed the Optimality Index-US. This tool focuses on the frequency of optimal events (practices that support NPB) versus the traditional focus on adverse outcomes.

The Lamaze International's *Six Lamaze Healthy Birth Practices* (2003), identifies six birth practices that health care providers can use as a guide to successfully support and promote NPB for low-risk pregnancies. Romano and Lothian (2008) adopted these recommendations to focus on nursing practices that support and promote NPB. The authors give evidence for the benefits of NPB, and emphasize the importance for nurses to adopt these recommendations into their nursing practice.

The literature supports the importance of the role of intrapartum nursing support for women in labor and birth, as well as the satisfaction nurses gain from providing care to women in pregnancy and birth. There is ample evidence to support the benefits of NPB for women in childbirth. However, only two published articles in the last 6 years specifically addressed the nurse's role in supporting and promoting NPB (Romano & Lothian, 2008; Zwelling, 2008).

The characteristics of the current generation of childbearing women play a role in shaping the maternity care system. Twenge (2006) provides a framework for understanding this generation, and terms it "the me generation." The present generation of women has grown up with a comfort and reliance on technology for information. With access to multiple forms of technology, today's generation has replaced the more traditional childbirth education classes with less reliable sources of

education, such as reality TV and the Internet. Consequently there was a perception from the participants in this study that women today are not as prepared for childbirth as their mothers were.

Five underlying beliefs about childbirth were identified in this study. They include: *(a) childbirth is a profound and empowering event in a woman's life, (b) providing care to women during childbirth is rewarding, (c) women should be supported in their choice for the type of birth that they believe is right for them, (d) women's satisfaction with the birth experience is important, and (e) intrapartum nurses are experts in the care of women in labor and birth.*

The majority of participants were led to intrapartum nursing by either personal experiences with their own childbirth (both positive and negative) or an experience with a close family member. A student nurse maternity experience during a clinical rotation also had a positive influence on the formation of beliefs about childbirth.

Several significant factors emerged from the data. These factors influence the way in which intrapartum nurses provide care to women in labor and birth particularly in relation to the co-morbidities associated with the increase in obesity for women of childbearing age (preeclampsia and diabetes). The co-morbidity factor has presented many challenges, and has consequently required an advanced set of skills for the intrapartum nurse.

Participants also identified other factors that they perceived to interfere or challenge the way in which nursing care is provided to women in labor and birth. The changing face of today's generation of childbearing women, the high rate of induction of labor, and the general lack of childbirth education are some of the factors identified.

Organizational factors such as the cultural environment of the medical model of birth, the high census of patients, staffing patterns, demands of electronic documentation and the underlying fear of medical litigation were all factors identified by the participants as having an effect on the way in which they provided nursing care. Last, the unpredictable relationship with attending physicians was acknowledged as a factor as participants weren't consistently recognized as experts in the care of women in labor and birth.

While participants were overall reticent to specifically express support for the benefits of NPB, more than half of the participants' perceptions of an ideal birth was one where the laboring woman experienced NPB. All of the participants believed that NPB was realistic for women only when they were healthy at the start of labor, motivated, and prepared for the rigor involved in NPB.

The data revealed that the medical model was often the path of least resistance for intrapartum nurses in this environment. Many women came in asking for anesthesia as soon as possible. They requested induction of labor prior to the onset of spontaneous labor and had little or no childbirth education. At least half of the participants believed that obstetrical providers needed to assume more responsibility in making sure that pregnant women understood the healthiest options for childbirth.

Conclusions

The intrapartum nurses who participated in this study believed that childbirth was an extremely important event in a woman's life and being part of this experience was rewarding. All of the participants believed that a woman's individual birth plan was important to recognize and acknowledge. This idea or the third belief was directly

linked with the fourth belief in which participants believed that when a woman had the type of birth she has envisioned for herself, she was more apt to be positively satisfied with her birth experience. All of the participants linked a woman's satisfaction with her birth to the quality of the nursing care provided. The fifth belief to emerge was, as intrapartum nurses, participants believed that they were experts in the care of women in labor and birth, and found it difficult when the attending physician did not recognize them as experts.

While these five beliefs provided an underlying framework for the participant's nursing practice, there was a disconnect that occurred between what was believed about childbirth and what was actually practiced. Three factors were identified to potentially explain this belief-practice gap. The first factor underlying the belief-practice gap was twofold-the broad view of birth as a risky and potentially dangerous event for all women, held by the majority of health care professionals providing care to women in labor and birth, and secondly, the overuse of technology to establish safety for the mother and fetus. The traditional maternity care system in the U.S. and other developing countries does not typically recognize the underlying belief that pregnancy and childbirth is a healthy, normal event in a woman's life. The use of continuous EFM is widely accepted as the standard to establish maternal/fetal well-being. This standard of practice for women who are at low-risk for complications in pregnancy and birth is not supported in the literature. EFM tethers women to machinery. It often starts the cascade of events leading to more invasive interventions and is physically confining to women who wish to listen to their bodies and use movement and position changes in labor and birth.

The second factor identified was the influence that the organizational culture had on nursing practice. The patient census and the potential for inadequate nurse-patient staffing ratios required the most efficient use of the nurse's time. Inadequate staffing patterns often contributed to nursing practices that were based in the medical model. The standardized policies that nurses had to abide by promoted an environment that undermined the individual uniqueness that women bring to labor and birth. The difficulties of balancing the use of electronic documentation with patient care, the underlying culture supporting the routine use of interventions as well as the unpredictable relationship that nurses had with attending physicians, were all organizational factors that affected the way in which intrapartum nurses provided care.

The third factor identified was the childbearing woman (or consumer). Participants believed that the present generation of childbearing women seemed comfortable with the intervention and technology that modern obstetrics had to offer. Participants also believed that many women today were not prepared for the rigors of childbirth and had unrealistic expectations for having a baby. This presented an inherent problem to the intrapartum nurses. While a cornerstone to the profession of nursing is education and the promotion of wellness, participants believed that admission to the birthing unit was not the appropriate time to educate women about safe and beneficial alternatives to the medical model of care. Several participants suggested that pregnancy and childbirth as a normal and healthy event should be ingrained in the minds of women of all ages, so when women did become pregnant whether planned or not, the experience was one of self-reliance and trust in one's body, rather than fear and anxiety about poor outcomes.

In conclusion, participants identified that the factors that most influenced intrapartum nursing practice were the dominant culture of the medical model, the culture of the organization where they practiced, and the characteristics of today's generation of childbearing women. These factors were found to be equally interdependent in the promotion, support and protection for NPB. All of the participants in this study believed that a woman must be healthy, motivated and prepared in order to successfully accomplish NPB.

Limitations

There were several limitations to this research study. The first limitation was the technique used for recruitment and enrollment. Snowball sampling was the sampling plan used in this study. This technique was at risk for bias. The first couple of participants recruited were what Polit and Beck (2012) referred to as "seeds." The referrals for the rest of the participants started with the two original seeds. This type of sampling limited the sample to a small network of acquaintances. The participants for the study were previously familiar with the researcher. While both snowball sampling and familiarity with the investigator could be perceived as an advantage to the study, it could also be seen as a limitation. However, the sample of participants for this study was eager to share their beliefs with a person they were familiar with and trusted. Other potential participants might not have been aware of the study, or familiar with the researcher.

The participants knew the investigator as a nurse-midwife who had practiced on the labor unit for almost 16 years and is currently practicing as faculty in baccalaureate nursing education. The concept of insidership may have been a potential

limitation. The participants may have been inclined to frame their answers in a way that they thought would be most acceptable, especially in relation to NPB. Every effort was made to avoid bias.

Another limitation was the homogeneity of the participants. All of the participants were women, with numerous years of intrapartum nursing experience (average length of practice was 24 years). This sample was not necessarily representative of other intrapartum nurses, in different childbirth settings. There may have also been different perceptions from a novice intrapartum nurse. Also, all but one participant worked on the day shift, therefore, the factors that influenced nursing care may have been limited to one shift's culture and perceptions.

The sample size of ten participants is considered small, but in qualitative research the sample number is less important than reaching *saturation*, meaning a point is reached in the collection of data where categories and themes start to reoccur, and no new information is gleaned from the research. Rubin and Rubin (2012) claim that, when saturation is reached, it is time to discontinue the research. Morse (2000) maintains that the broader the research questions, the longer it takes to reach saturation. This author also supports that the quality of the data obtained also affects the saturation point. Saturation for this research study was reached after nine interviews, which may possibly relate to the homogeneity of the sample.

Sandelowski (1995), a qualitative research expert, maintains that sample size in qualitative research does matter to the credibility of the study. The author believes that determining a sample size is a matter of judgment and the experience of the researcher and an evaluation of the data collected. Where the researcher for this study is a novice

and the experience of analysis has been a learning process, the sample size is a potential limitation to the findings in this study.

Last, the ability to transfer findings to other populations in qualitative research is limited. Because the sample was small and limited to intrapartum nurses practicing in a very particular setting of maternity care, it is difficult to transfer these findings to all intrapartum nurses practicing in other types of intrapartum settings in the U.S.

Implications

Significant to the development of nursing knowledge in the practice domain, this research study seeks to provide an understanding of the underlying beliefs that intrapartum nurses had about childbirth and NPB. As frontline care providers, intrapartum nurses are uniquely positioned to be an important voice for the improvement of quality and safety for maternity care in the U.S.

Future research. There are many areas in maternity and obstetrical care that need further study. The benefits of NPB and the disadvantages of the routine medicalization of childbirth are essential topics for research in the 21st century. As frontline care providers, further research on the nurse's role in the promotion and support of NPB, as well as barriers and facilitators to identify NPB practices are critical.

Existing evidence to support the benefits of NPB has been slow to be accepted, not only by women as consumers of health care, but by obstetricians as well. Public health campaigns should be focus at the community, state and national levels to promote the advantages of NPB for the majority of women. At the same time, the

routine use of interventions should be reserved for women with complications and risk factors in pregnancy and birth.

Future research efforts should be made to examine the Bologna Score instrument as a tool to measure practices that promote NPB, and best birth practices. Once the instrument has been established for reliability and validity, researchers could conduct a pilot study using retrospective chart review, participant observation or descriptive interviews of women who have recently given birth. The Optimality Index (Murphy & Fullerton, 2009) is also an instrument that needs further study, especially in a large volume hospital setting. Results from the use of instruments to measure optimal care and NPB outcomes could then be compared with the morbidity and mortality benchmark measures and patient satisfaction surveys that are already in place, and presented to the decision and policy makers at maternity care institutions.

Nurses, as valuable members of every health care team, should consistently participate and be included in research of care practices, processes and outcomes on the frontlines of maternity care. This is especially important in relation to changes in the birthing unit cultures that would not only enhance the environment for women in labor and birth, but also increase the professional satisfaction for nursing practice.

Future research is needed to examine the beliefs of intrapartum nurses in different maternity settings, such as in-hospital and out-of-hospital birth centers and community hospitals. Results of this research could be made available to women as consumers in order to assist women with where they might choose to receive maternity care. Potential findings for a study like this might reveal that tertiary care hospitals, where the medical model is often the usual practice, might be reserved only for the

high-risk mother and infant. Community hospitals or out-of-hospital birth centers might be a better environment for the promotion of NPB.

Research is also needed about the perceptions of childbirth in this generation's women. Evidence for this topic is not available in the literature. It is important to identify generational ideas about childbirth so health care providers can better meet the needs of women and to create more creative ways to disseminate best evidence and provide a safe and satisfying childbirth experience.

Continued research is needed to further understand the nurse's role in the rising cesarean delivery rate. While a couple of nurses in this research study expressed that the decision to proceed with a cesarean delivery (or not) was ultimately the physician's responsibility, nurses are closely involved in the care of women in labor and birth. WHO (1996) suggests a cesarean delivery rate of 15% or less. This indicates the need for the U.S. cesarean delivery rate to decrease by approximately 50%. As frontline maternity care providers, nurses should be at the table for this important discussion.

Available research that explores nursing care and patient outcomes, especially in maternity care, is limited. Intrapartum nursing care is optimum for research that examines the association between nursing care and patient outcomes. This is because of the patients' limited exposure to different health care providers involved in direct care, the high volume of patients, and the short period of time patients are exposed to nursing care (Miltner, 2000).

Theory development. Theory development is important for all disciplines. A theory provides guidance for the understanding of how concepts and constructs link together. In clinical practice, theory development helps to explain why some clinical

practices are effective, and others are not. NPB does not have a standard definition or a theoretical background. While attempts have been made to define NPB, and several concept analyses have been published, theoretical support for NPB has not been well developed. Kennedy's midwifery model of care (1999) is perhaps the closest theory identified for understanding practices that support NPB and the beneficial outcomes; however, it is not directly focused on nursing practice. Kennedy's model focuses on the dimensions of midwifery care, the processes, and outcomes. The support for normalcy is specifically identified as a process of midwifery care, and is linked to the exemplary outcomes associated with midwifery care.

Ajzen's (1991) Theory of Planned Behavior (TPB), supports that behaviors are preceded by a set of beliefs. The TPB is based on the assertion that individual behavior, defined as an observable response in a given situation, or set of actions that an individual performs based on compatible intentions, can be predicted by intent to perform that behavior. This is called behavioral intentions (Fishbein & Ajzen, 1988).

Attempts to understand how intrapartum nurses' beliefs affect the way they practice can be better explained using the TPB as a theoretical framework. Whether or not nurses' beliefs affect their practice can potentially be explained by the concepts of perceived control over their environment, importance of submission to social norms or underlying attitudes toward birth and women in general. Identifying variability in the intent to perform nursing actions that support NPB may be helpful to determine barriers and facilitators for nursing practice.

Feminist theory is also of theoretical value for this research study. Downe (2008) maintains that the history of childbirth in westernized cultures has created

elaborate rules to create control and constrain “creative female power” (p. 35). Cartesian Dualism, the separation of mind and body, supports the idea of women’s bodies as an object, belonging to the health care provider (Goldberg, 2002). The idea of women being supported in the experience of childbirth as a holistic, individualistic experience, unique to women, supports the tenants of feminist theory. When discussing feminine perspectives of childbirth, Downe (2008) argues that some feminists believe that healthcare providers who offer pain relief to women in childbirth may be perceived as agents of the patriarchal oppression, supporting the western centric medical model of childbirth. Downe also claims that feminists have argued that for a midwife to offer a woman pain medication in childbirth fosters the image of women as weak and dependent. Conversely, some feminists believe that encouraging women to experience birth without anesthesia or pain medication has potential negative consequences (Beckett, 2005). From both perspectives, Feminist theory has the potential to support research findings surrounding the complex issues of childbirth.

Antonovsky’s theory (1979), also known as *Salutogenesis*, focuses on the promotion of health and well-being and potentially provides a theoretical background to support the concept that childbirth is a normal, healthy event in a woman’s life. New tools for measurement of optimal outcomes for women in childbirth might adopt the Theory of Salutogenesis as a theoretical foundation.

Nursing education. New pedagogies for baccalaureate maternity nursing education must be explored. Giarratano, Bustamante-Forest, and Pollack (1999) suggest a curriculum that is grounded in women centered care, feminist teaching, storytelling and spirituality, in addition to the traditional scientific curriculum. Similar

to what was previously discussed about the theoretical development for childbirth, nursing care for the woman in pregnancy, labor and birth should be taught from the standpoint of normal, emphasizing it as a physiologic event in women's lives.

Education and clinical instruction for the high-risk complications should be viewed as the exception. The curriculum for maternity nursing education must provide student nurses the opportunities to explore and reflect on the ways women's choices for childbirth are defined, affected, and limited by a healthcare system that is dominated by the medical model of care. Clinical opportunities to observe normal birth are all recommended for student nurse education.

The recommendation for childbirth educators to help women develop realistic birth plans and prepare for this significant event cannot be understated. Childbirth educators must start to revisit the content of what they teach, and create new and engaging ways to educate women. The past methods of childbirth education in the traditional classroom do not meet the needs of the new generation of learners. The following needs to be considered: Are childbirth educators teaching to the institution's policies and menus of options? Is the content supported by best available evidence?

All obstetrical care providers, physicians, midwives, and nurses have a great deal of responsibility to make sure women are well informed of the advantages and disadvantages of the many options available to them. Obstetric care providers may feel they don't have the time for this practice in the traditional 15 minute prenatal visit. The possibility of registered nurses in the prenatal ambulatory setting whose sole function is to educate, inform, and promote the health and well-being of pregnant women should be considered as an option.

Administration. The organization's administration, those individuals who set policy and create standards and influence the environment of care, have the obligation to be aware of the most current evidence, and make decisions which are non-judgmental and based on evidence based practices. Administrators also have an obligation to respect and consider the professional nursing organization's recommendations for patient care. AWHONN, the professional organization of intrapartum and neonatal nurses, has a comprehensive set of evidence-based standards for safe nursing practice. While the economic side of the organization is important, it should not take priority over best practices and professional standard recommendations.

Members of the organizations decision-making team should strive for interprofessional teamwork. Nurses should have formal input to promote a unit culture that is supportive of women in labor and birth. Staffing configurations, the creation and maintenance of evidence-based guidelines, reasonable documentation tools and education for new practices and procedures should be part of the nurse's professional role on every birthing unit. Nurses should be supported and encouraged to take time to understand the most current research. As respected colleagues and providers of intrapartum care, nurses should be encouraged and expected to challenge management decisions they believe are not in the best interest of women in labor and birth.

Last, administration and professional organizations should support a formal certification process for nurses focusing on the promotion and support for women in NPB. This would increase the knowledge and skills required to assist women in NPB

and would be similar to the certification for EFM and high-risk intrapartum nursing care, often required by institutions.

Nursing practice. Findings from this research support factors that affect the way in which intrapartum nurses provide care to women. While the hospital administration has a responsibility to acknowledge the evidence and best practices, it is also essential for intrapartum nurses to assume a similar responsibility and proactively strive to participate in the changes that promote the beneficial aspects of NPB. Nurses must also be proactive and request to be included in all interprofessional committees and activities in their organization, especially where guidelines, policies, measurement, and outcomes are decided. They must realize their influential position to provide education to women regarding birth as a normal healthy event. They also need to expand their role to become advocates for safe birth. While many nurses take continuing education and advanced certification courses to increase their technology skills, they must also engage in activities to further expand their knowledge and skills of NPB.

All nurses should be encouraged to reflect on their own personal philosophies about childbirth, and identify ways in which their practice does or does not reflect their beliefs and attitudes. Nurses have the potential to influence the perception of childbirth to as a normal, healthy experience, innate to the vast majority of women in the U.S.

Appendix A

Qualitative Interview Guide

Intrapartum Nurses' Beliefs about Childbirth

Qualitative Interview Guide

This guide includes a few key examples of the kind of open-ended questions, which are intended to cover all domains of interest. The probes are meant to clarify, expand on and provide more detail if necessary.

Interview Guidelines *[read by interviewer]*

The purpose study is to explore intrapartum nurses' beliefs about childbirth to see how these beliefs may influence clinical practice and support specific evidence-based practices. I will have some specific topics to discuss with you, but I would like the discussion to be informal so that you can respond to any of the ideas or questions that arise. If you don't understand a question, please let me know. Please feel free to speak openly and honestly. There are no right or wrong answers, what matters most is your honesty. You are free to refuse to share personal information about yourself during the interview and we can stop at any time if you are uncomfortable with any of the topics that come up during our conversation. You have already completed the informed consent, which describes the study in detail. As a reminder, I will be tape recording this session. Do you have any other questions before we begin? Are you comfortable with what I have talked about thus far?

[Turn on audio recorder]

This is *[interviewer name]* conducting *[interview with participant ID #]* on *[date]*.

Participant ID: _____

1. Can you tell me your experience as a labor and delivery nurse starting early on in your professional career?

Probes

- a. What kinds of things in your life factored into you becoming a labor and delivery nurse, if any?
- b. Do you think what you learned in nursing school corresponds with how you practice intrapartum nursing care today? How is it the same or different?
- c. Have you practiced in other maternity care settings?
- d. Have you enjoyed your experience as an L and D nurse?
- e. What do like or dislike about caring for women in labor and birth? Has it always been this way or have your thoughts changed over time?
- f. Do you believe that you have a voice to create change and lead the way for healthy mothers and babies?
- g. What about the profession of nursing in general, are nurses in a strong position to have their voice heard and lead the way for change?

Notes

Participant ID: _____

2. What are your beliefs about labor and birth?

Probes

- a. What are your underlying thoughts and beliefs about labor and birth?
- b. Are these beliefs consistent with the culture of care in this maternity care setting?
- c. Have your beliefs changed over time? And if so, how?
- d. How would you describe a typical labor and birth for a low risk woman in your hospital setting? How does this description match with your underlying beliefs about birth?
- e. Briefly describe what you believe to be a great birth experience for a low-risk mother in labor and birth.
- f. What do you believe about routine medical interventions in labor and birth in the US and in your own hospital facility (e.g. cesarean delivery, elective induction of labor, IV fluids, continuous fetal monitoring, augmentation with pitocin, epidural anesthesia)?

Notes

Participant ID: _____

3. How do you think your beliefs about labor and birth influence the way you practice nursing and provide care for women in labor and birth?

Probes

- a. Do you believe that intrapartum nurses are uniquely positioned to influence outcomes for mother and baby? If so, please give an example.
- b. On this unit, do you think your beliefs about labor and birth emphasize the way you provide nursing care?
- c. Has it always been this way on this particular unit? Do you think it is different in other places and settings in maternity care? If so, what are the differences and why do you think so?

Notes

- 4. Lamaze International has developed six care practices that support and promote normal physiologic birth. Roman and Lothian (2008) applied the six care practices specifically to nursing care for women in labor and birth. What do you think about the six nursing practices that promote and support NPB?**

Probes

- a. Do you see these practices being regularly being carried out on this maternity unit? Why or why not?
- b. Are the six care practices realistic for care in this setting? Why? If yes, what are the facilitators to practice in this way? If no, what are the barriers to practicing in this way? Are there other settings that might or might not be more realistic? Why?

Notes

Six care practices:

- ~Labor begins on its' own (support and advocate for spontaneous onset of labor unless medically necessary).
- ~Encourage freedom of movement throughout labor and birth.
- ~Encourage and support continuous labor support (doula, family member or partner).
- ~ Avoid routine interventions (continuous fetal monitoring, IVs, epidural anesthesia)
- ~Spontaneous pushing in non-supine position
- ~No separation of mother and baby after birth

Participant ID: _____

5. What barriers and facilitators do you see that interfere or promote nursing practices that support NPB?

Notes

Appendix B

Recruitment Letter

Intrapartum Nurses' Beliefs about Childbirth

You are being asked to participate in a research study. It is important that you know the following:

- Your participation in this study is entirely voluntary.
- You can ask questions now or anytime during the study.
- If you join the study, you can change your mind later and quit the study at any time.

Before you decide whether to join this study, the researcher will explain:

- The purpose of this study
- How the study may help you or others
- Any risks you may face while being in this study
- Confidentiality of your study data
- What is expected of you during the study

Once you understand the study, and if you decide to take part, you will be asked to sign a consent form, and you will be given a copy of it to keep. This process is called *informed consent*.

What is the purpose of this study?

The purpose of this study is to explore intrapartum nurses' beliefs about childbirth to see how these beliefs may influence clinical practice and support specific evidence-based practices.

How long will this study last?

Your participation will consist of a one-time interview. The interview visit will last approximately one to two hours.

How many people will be in this study?

Fifteen intrapartum registered nurses will be participating in this study.

Who is conducting this study, and where is it being conducted?

Sylvia (Closson) Ross, CNM, PhD(c), doctoral student at the University of Rhode Island is conducting this study as part of the completion of her doctoral dissertation at the College of Nursing. Dr. Deborah Erickson-Owens, CNM, PhD, faculty at University of Rhode Island College of Nursing is the primary investigator overseeing this study. The interview will take place in a mutually agreed upon quiet setting, other than the hospital.

What are the requirements to be in this study?

To be part of this study, you must be between the ages of 18 – 70 years old, currently employed as an intrapartum nurse practicing on the labor and delivery unit of a hospital, English speaking and willing and able to provide written informed consent. Eligibility will be based on self-report.

What do I have to do if I am in this study?

The study visit will take place in a mutually agreed upon quiet setting. You will need to indicate that you voluntarily agree to participate in the study by signing a consent form. Sylvia Ross will answer any questions you have before you sign the consent.

Can I change my mind about participating in this study?

You can agree to be in the study now and change your mind at any time during the study visit. If you wish to stop, please just let us know.

What are the risks and discomforts associated with this study?

There are minimal risks to your participation in this study. Some of the topics covered in the interview could make you feel uncomfortable. For the interview and questionnaire, you are free to skip any question that you'd rather not answer. You are also free to stop participating in this study at any time.

Although the risk is low, a break in the confidentiality of your research records may occur. Only members of the research team will have access to your study records. Your records will be securely stored in a cabinet in the primary investigator's locked office.

What are the benefits of participating?

Although it is not likely that you will personally benefit from taking part in this study, you may find it reflective and insightful. The researcher hopes to learn more about nurses' beliefs about labor and birth, and if these beliefs potentially influence nursing care and related outcomes for mothers and babies.

How will my confidentiality and privacy be protected?

Your confidentiality and privacy are our top priorities. We will keep all the information you give us confidential as provided by law. Access to electronic and hard copy files is restricted to relevant study staff. All study records will be kept confidential and stored in a locked cabinet. Data will be identified by a unique participant code only. A password protected electronic document linking names and codes will be kept but only study staff have access to this document. Any document with your name on it will be stored separately from research data.

Will I receive any payments?

If you choose to enroll in the study, you will receive a \$25 gift card as reimbursement for your time.

Who do I contact if I have questions about participating in this study?

If you have any questions about the study, you may discuss your concerns or questions with Sylvia Ross, (401-835-3747), sross@ric.edu or Dr. Debra Erickson-Owens (401-874-5344), dericksonowens@ds.uri.edu anonymously, if you choose.

Appendix C

Consent Form for Research

**The University of Rhode Island
College of Nursing
White Hall, 39 Butterfield Road, Kingston, RI 02881**

Intrapartum Nurses' Beliefs about Childbirth

Consent Form for Research

Introduction to research

You are being asked to volunteer for a research study. It is important that you know the following:

- Your participation in this study is entirely voluntary
- You can ask questions now or anytime during the study
- If you join the study, you can change your mind later and quit the study at any time

Before you decide whether to join this study, a member of the study staff will explain:

- The purpose of this study
- What is expected of you during the study
- Any risks you may face while being in this study
- Confidentiality of your study data
- How the study may help you or others

You have already been determined fully eligible for this study. This document is the informed consent. You will need to indicate that you voluntarily agree to participate in the study by signing this document. All of your questions will be answered before you sign.

What is the purpose of the study?

The purpose study is to explore intrapartum nurses' beliefs about childbirth to see how these beliefs may influence clinical practice and support specific evidence-based practices.

What are the requirements to be in this study?

You are being asked to participate in this research study because you: are over the age of 18 and are currently employed as an intrapartum nurse in a hospital setting.

How long will the study last?

This is a one-time study visit that will take approximately 2 hours.

Who is conducting this study, and where is it being conducted?

This study is being conducted by Sylvia Ross, PhD(c), RN, a doctoral student from the University Of Rhode Island College Of Nursing.

What do I have to do if I am in this study?

If you choose to take part in this study, you will complete a one-time brief demographic questionnaire and an in-depth interview.

Brief demographic questionnaire

You will complete the questionnaire on your own. It contains questions about your age, race/ethnicity, educational background, childbirth history, and employment.

Interview

The investigator will conduct an in-depth interview with you that will last approximately 1 hour. The interview will ask you questions about your professional and personal experiences and viewpoint on labor and childbirth. The interview will be audio-recorded to ensure that we capture everything that you say. You will also be contacted via email or telephone after the study visit by the interviewer. She will review the notes she has taken on what you discussed in the interview so she can ensure it was accurately understood.

What are the risks and discomforts associated with this study?

There are minimal risks to your participation in this study. Some of the topics covered in the interview could make you feel uncomfortable. For the interview and questionnaire, you are free to skip any question that you'd rather not answer. You are also free to stop participating in this study at any time.

Although the risk is low, a break in the confidentiality of your research records may occur. Only members of the research team will have access to your study records. Your records will be securely stored in a cabinet in the investigator's locked office. For more information see the section: *How will my confidentiality and privacy be protected?*

What are the benefits of participating?

Although it is not likely that you will personally benefit from taking part in this study, you may find it reflective and insightful. The researcher hopes to learn more about nurses' beliefs about labor and birth, and if these beliefs potentially influence nursing care and related outcomes for mothers and babies.

Will I receive any payments?

If you choose to enroll in the study, you will receive a \$25 gift card as reimbursement for your time.

How will my confidentiality and privacy be protected?

Your confidentiality and privacy are our top priorities. To maintain privacy, this study visit is being held in a room where others cannot overhear us. We will keep all the information you give us confidential as provided by law. Access to electronic and hard copy files is restricted to relevant study staff. All study records will be kept confidential and stored in a locked cabinet. Data will be identified by a unique participant code only. A password protected electronic document linking names and codes will be kept but only study staff have access to this document. Any document with your name on it will be stored separately from research data.

All information disclosed to the researchers will remain confidential. No individual identities will be used in any reports or publications that may result from this study. The study will maintain all study documentation for at least five years after the completion of the study.

What if I decide to end the study visit early?

The decision to take part in this study is voluntary. You do not have to participate. If you decide to take part in the study, you may decide to withdraw at any point during the study visit, just let the investigator know. Researchers may continue to use information already collected to protect the integrity of the study.

Who do I contact if I have questions or problems?

If you are not satisfied with the way this study is performed, you may discuss your concerns with Dr. Debra Erickson-Owens (401-874-5344) anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

Consent

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study.

Signature of Participant

Signature of Researcher

Typed/printed name

Typed/printed name

Signature of participant's agreement to be audiotaped.

Date

Date

Please sign both consent forms, keeping one copy for yourself

Appendix D

Contact Information Form

Intrapartum Nurses' Beliefs about Childbirth

**Contact Information Form
Version 1.0**

First name: _____ Last name: _____

Telephone: (____) _____ - _____ (*circle one*) MOBILE HOME WORK

Email address: _____@_____

Address: _____

Appendix E

Brief Demographic Questionnaire

PARTICIPANT ID	DATE

Appendix E

Intrapartum Nurses' Beliefs about Childbirth

Brief Demographic Questionnaire

Thank you for taking the time to complete this demographic questionnaire. This instrument will ask you questions about your background, education, and professional experience. If you do not feel comfortable answering a particular question, feel free to skip that question. All answers you provide are strictly confidential and are protected as outlined in the informed consent form. If you have any questions before you start the survey, please feel free to ask.

Thank you,

Sylvia P. Ross CNM, PhD(c)

Participant ID: _____

1. What is your date of birth? ____/____/____
2. My gender is:
 - Male
 - Female
3. How would you describe your racial identity? *(check all that apply)*
 - White/Caucasian
 - American Indian or Alaska Native
 - Asian
 - Black/African American
 - Hispanic/Latino
 - Pacific Islander
 - Other (Specify _____)
4. I have completed the following degrees: *(check all that apply)*
 - Masters in Nursing
 - Masters of Science in Nursing
 - Bachelor of Science in Nursing
 - Associate Degree of Nursing
 - Diploma of Nursing
 - Other (please specify _____)
5. Are you currently: *(check all that apply)*
 - Employed full-time (36+ hours per week)
 - Employed part-time (<36 hours per week)
 - Per Diem
6. Are you currently:
 - Married
 - Separated
 - Divorced
 - Other (specify _____)
7. How many times have you given birth: _____
8. Please select all that apply. I have had experience working in the following maternity settings:
 - Community Hospital
 - Free standing birth center
 - In hospital birthing center
 - Home birth setting
 - Magnet Hospital
 - Level 1 Hospital
 - Level 2 Hospital
 - Level 3 Hospital

Participant ID: _____

9. I have the following certifications: *(check all that apply)*

- Electronic fetal monitoring
- In-patient intrapartum nursing
- Childbirth Education
- Certified Nurse-specialist
- Doula
- Other (specify _____)

10. How many years have you worked as an intrapartum nurse? _____

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