EXPLORING THE WORKING RELATIONSHIP BETWEEN
LABOR AND DELIVERY NURSES AND
CERTIFIED NURSE MIDWIVES

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ABSTRACT

Bowlby’s Theory of Planned Behavior states that a person’s beliefs predict their behavior (Davina, 2001). Therefore, labor and delivery (L/D) nurses’ beliefs about childbirth and Certified Nurse Midwives (CNMs) influence the behavior of L/D nurses providing care alongside CNMs. The purpose of this study was to explore the working relationship between L/D nurses and CNMs to better understand the factors for reported conflict and barriers towards positive relationships. Investigators employed a qualitative descriptive approach by using open-ended questions during audiotaped focus groups and individual interviews. A sample of 15 L/D nurses and 13 CNMs in the Dallas Fort Worth (DFW) area was obtained using social media. Conventional content analysis was used to identify themes consistent throughout the data. Investigators isolated three distinct themes that contribute to reported conflict within the working relationship of L/D nurses and CNMs: differing world views, experiencing roles, and overlapping roles. The findings of this study prompt the need for educational interventions for hospital administration and labor and delivery staff as well as the need for further research surrounding policies in facilities reporting minimal conflict between these two groups.
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Introduction

Workplace aggression is not uncommon, but it has been increasingly prevalent among nurses and Certified Nurse Midwives (CNMs) in the past decade. Despite their common backgrounds as Registered Nurses (RNs), Labor and Delivery (L/D) nurses tend to bully midwives in the hospital setting, resulting in poor workplace stability for CNMs. This is termed the “exodus” of midwives from the hospital setting. Workplace victimization involves acts of aggression perpetrated by one or more members of an organization that cause psychological, emotional, or physical harm to their intended target (Aquino & Thau, 2009). Among intrapartum nurses and CNMs, this aggression manifests most commonly in the forms of rudeness, undermining, sarcasm, exclusion, or unjustified criticism (Farrell & Shafiei, 2012).

Midwives are the most popular provider of childbirth worldwide, accounting for the birth of 80% of people on the planet (Foley, 2005). The United States, which holds one of the highest infant mortality rates, is unique in that physicians attend most births, rather than midwives. Neonatal outcomes in the United States (US) for babies born by midwives are outstanding. Benatar, Garrett, Howell, and Palmer (2013) showed that when compared with hospital births performed by physicians, births with the assistance of midwives had fewer Cesarean sections (C-sections), lower use of forceps, fewer preterm births, and higher birth weight.

There are many types of midwives in the US, and this may have some influence on their national perception due to the varied educational requirements within this professional group. Generally, midwives who work in the hospital setting are CNMs. This profession requires a Bachelor’s degree in nursing and a Master’s degree in midwifery. Midwives must also pass a national exam to achieve certification. Traditional midwives are independent practitioners
trained via apprenticeship. Although these midwives form much of the nation’s perception, they do not practice in hospitals and are not the focus of this study.

Incivility between L/D nurses and midwives creates instability in hospitals and can become a confounding factor in the quality of patient care. Bickering nurses are doing little to provide for and protect their patients; therefore, this issue is of great importance to nursing practice. By identifying the root causes of incivility and bullying among these nurses, changes in practice can be made to reduce vulgarity, increase organizational stability, and ultimately improve patient care. The specific clinical question is as follows: What are the barriers to positive relationships between L/D Nurses and CNMs?

**Literature Review**

A search of CINAHL Complete, MEDLINE, Cochrane Library, Joanna Briggs Institute, and Nursing & Allied Health Database identified studies reporting factors that affect workplace victimization. The student researcher only considered articles written in English. Search terms included *conflict* AND *midwi* AND *intrapartum nurs*. Other search terms included *perception*, *attitude*, *incivility*, *mobbing*, *patient outcomes*, and *education* to further lay the foundation of knowledge regarding the history of midwives, their national perception, their education requirements, and statistics on their maternal and neonatal outcomes. The student researcher appraised the current literature using the John’s Hopkins’ Research Appraisal Tool. Articles ranged primarily within levels III and IV (see Appendix B) (Dang & Dearholt, 2017).

**Role Overlap**

Two articles examined L/D nurses’ role identities and role conflicts when working with a CNM. Quance (1997) noted many areas of role overlap among L/D nurses and CNMs including knowledge of the normal process of labor, risks, abnormalities of labor, the ability to perform
vaginal examinations, assessment of the newborn, ability to provide emotional and physical comfort, and the ability to educate the woman on labor and pain control. Ayala, Binfa, Vanderstraeten, and Bracke (2015) defined this role overlap as horizontal expansion, in which professional boundaries become blurred. In Quance (1997), nurses reported feeling that it was difficult to establish a rapport with the patient when a midwife or doula was present. Caldas, Santos, Andressa, Santana, and Lenho (2016) discussed the idea of a hybrid professional identity where midwives find themselves fulfilling the roles of both nurse and midwife. As explained in Quance (1997), role overlap leads to role ambiguity. This uncertainty about who does what, when, and where ultimately causes conflict. Division of labor promotes cooperation, but role overlap drives competition (Ayala et al., 2015).

**Work Overload and Structural Issues**

Bogossian, Winters-Chang, and Tuckett (2014) validated the difficulty of nursing work. Features such as staffing ratios, increasing patient numbers, level of acuity, and the volume of paperwork were defined as “hygiene factors” which, if adequately addressed, prevent dissatisfaction and motivation to leave. The researchers claimed that lateral violence or incivility towards a coworker arises from these disenfranchising work practices, and manifests as a safe way to release tension (Bogossian et al., 2014). Farrell and Shafiei (2012) reported other factors that drive workplace aggression among nurses include lack of training, poor management, and poor communication between staff. Demir and Rodwell (2012) found that low levels of job control and low levels of supervisor or colleague support were associated with higher levels of workplace bullying. Additionally, Demir, and Rodwell (2012) found that high levels of workplace bullying were associated with low organizational commitment levels. The researchers posit that when workplace bullying occurs, the victim may attribute the blame to the organization
they work for, either for hiring the people that acted uncivil or for allowing a culture of workplace aggression. This aggression may also be a factor driving the exodus of CNMs.

**History and Perception of Midwives**

Midwifery began as the ancient practice of women attending other women in childbirth (Foley, 2005). In the United States, many public health nurses found themselves delivering babies at home when physicians arrived too late. With the baby boom after World War II, there simply were not enough physicians to attend every birth, especially those in rural communities. Nurse-midwives proved to be a satisfactory solution to the problem of maternal care (Dawley, 2003). Historically, midwives cared for low-income groups and trained through apprenticeship. As a result, the public viewed them as uneducated and only capable of assisting a natural process (Ayala et al., 2015). Women’s health activism has since changed the way many women want to experience birth, and for this reason, the midwifery profession has expanded greatly. A master’s degree is now required to become a CNM. Certified Nurse Midwives were incorporated into the hospital setting in order to teach childbirth classes, support women in labor, provide postpartum education, and offer a woman-centered birth experience (Dawley, 2003). Despite this progress, stereotypes regarding CNMs remain prevalent. Johnson (1998) showed that a large majority of the population report being uncertain of CNMs’ level of education, scope of services, and relationship to the health system. Perception of midwives even varies from state to state within the U.S., with the greatest support being in the Northeast and the West, and the lowest support being in the Midwest and the South (Raisler, 2000). Public perception of midwives may be the foundation upon which intrapartum nurses form their beliefs.

**Differing Birth Philosophies**
Midwives emphasize that birth is a natural process, that labor pain is expected, and that the newborn and mother are a unit. CNMs focus on involving the laboring woman as an active participant during her pregnancy through education and empowerment (Baldwin, Hutchinson, & Rosenblatt, 1992). This philosophy is termed the “midwifery model.” The “medical model” posits that birth is a potentially dangerous situation and that interventions such as electronic fetal monitors or C-sections are necessary to prevent the unexpected (Quance, 1997). This idea is exemplified through the higher number of pre-term deliveries and C-sections and the lower number of weekend deliveries when compared to CNMs (Benatar et al., 2013). Quance (1997) related the electronic fetal monitoring system to a pacifier for L/D nurses, stating that nurses have become so used to monitors and epidurals that they are unable to shift the focus back to the mother-baby connection and the natural birth process. As explained in Caldas et al. (2016), this conflict in birth philosophies makes it difficult for CNMs to practice in hospitals where practitioners value intervention procedures and biomedical technologies, and doctors are the most influential professionals in the conduct of care.

**Education**

There are limited studies on the influence of education on nurse attitudes and incivility. Foley (2005) suggested that standardized education and Bachelor of Science in Nursing (BSN) programs are moving in the direction of the medical model, and that this has a damaging effect on the autonomy and independence of midwifery practice. Quance (1997) proposed that because the clinical experience for the maternity setting is confined to the hospital, nurses are educated to believe that birth is best done in a hospital setting. Ayala et al. (2015) posits that the education of nurses and CNMs in separate schools results in little contact and a lack of opportunities to identify and valorize each other’s knowledge and skills. Therefore, the opposing identities rest
upon unawareness and discourse of differentness, rather than on a fundamentally different educational ground (Ayala et al., 2015). There are few studies exploring the education provided for baccalaureate nursing students regarding the various forms of advanced practice nursing, or whether experience and exposure influences nurse opinions towards CNMs.

**Theoretical Framework**

The theoretical framework that will inform this study is Bowlby’s Theory of Planned Behavior, which stems from Symbolic Interactionist Theory (Levine & Lowe, 2015). The symbolic interactionist theory stems from George Herbert Mead’s idea that humans develop their personal identities through interaction with others (Davina, 2001). Herbert Blumer expanded this thought when he developed the Symbolic Interactionist Theory, explaining that people act a certain way towards things based on the meaning those things carry to the individual. Individuals impose subjective meanings on objects, events, and behavior in the context of social interaction. These beliefs then influence behavior because individuals act based on these meanings rather than what is objectively true (Askan, Kısaç, Aydin, & Demirbüken, 2009). A model adapted from Smit and Fritz (2008) further explains this theory (see Figure 1) in Appendix A.

**Conceptual and Operational Definitions**

In the context of this study, L/D nurses develop their opinions of CNMs through interactions with Obstetricians and Gynecologists (OBGYNs), other intrapartum nurses, and CNMs themselves. Therefore, the beliefs of OBGYNs and other intrapartum nurses likely influence the attitudes and beliefs of a new L/D nurse. Symbolic interactionism posits that people tend to act on what they believe to be true based on their interpretations, yet these interpretations may not be grounded in reality.
Quance (1997) defines role ambiguity as occurring when the expectations within the role are incomplete or insufficient to guide behavior. Role stress is a social structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet. Unit culture is a measurement of common thoughts, behaviors, and beliefs particular to an organization or unit. Role overlap exists when two roles have only a few behaviors that are different. Perceptions are views of performance of oneself or others, past or present (Quance, 1997).

Methodology

Design

This was a qualitative descriptive study using focus groups to explore the working relationship between L/D nurses and CNMs. Texas Christian University’s Institutional Review Board approved this study. Recruitment began in August 2018.

Sample

Labor and Delivery nurses and CNMs currently employed in the Dallas Fort Worth area with at least one year of nursing experience in obstetrics were considered eligible for participation in this focus group. Exclusion criteria included any nurse with less than one year of experience in obstetric nursing, nurses not employed in the Dallas Fort Worth area, nurses without workplace exposure to CNMs, and non-English-speaking individuals.

Recruitment

The student investigator recruited 15 L/D nurses and 13 CNMs currently working in the Dallas Fort Worth area. The faculty and student investigators used social media, snowballing, and word of mouth to identify potential participants and explain the purpose of the study (see Appendix G). Interested participants contacted the student investigator via email. The student
investigator responded with a scripted email response (see Appendix H) to determine eligibility of the participant and schedule the focus group or individual interview.

**Setting**

The student researcher allowed interested, eligible participants to choose between scheduled focus group dates and times. Due to difficulty in scheduling, only one focus group was conducted. The focus group occurred in a private conference room in Bass Hall. The focus group was exclusive to CNMs. Cookies and water bottles were provided as compensation for participation. The rest of the participants were interviewed individually via telephone.

**Data Collection**

At the time of the focus groups or individual interviews, the student investigator thoroughly explained the study and the expectations for the focus group (see Appendix D). All participants signed the consent form (see Appendix C). All participants also completed a demographic data sheet (see Appendix E) prior to participating in the focus group or individual interview and were given a randomized number to self identify with for confidentiality purposes. The student followed the focus group question script to ask the participant(s) a series of open-ended, questions (see Appendix F). Follow up questions and prompts were used as needed. To ensure reliability and credibility, the student researcher lead the focus groups or individual interviews while the faculty researcher took field notes and interjected follow up questions as necessary. The focus groups and interviews were audiotaped.

**Results**

**Qualitative Analysis**

Interview questions focused on participant’s beliefs about the following: role definitions, birth philosophy, and relations between L/D nurses and CNMs. The questions were designed to
reduce investigator bias by being open-ended to allow for personal interpretation. Following professional transcription, the investigators individually analyzed the focus group and interview transcriptions. The student and faculty investigator used conventional content analysis procedures to analyze transcription line by line (Hsieh & Shannon, 2005). The researchers reviewed the transcripts several times to get a thorough understanding of the ideas presented. After completing data analysis individually, the student and faculty investigators collaborated to assure reliability in the findings. The third research assistant was present to review any discrepancies. The goal of the analysis was to identify barriers to positive relationships between L/D nurses and CNMs through themes and concepts elicited in the participant’s responses (Mojtaba, Hannele, & Terese, 2013). Analysis continued until thematic saturation was reached. Three main barriers, with additional subthemes, were identified: differing world views, experiencing roles, and overlapping roles.

Differing world views. A recurring theme repeated by participants was that conflict between L/D nurses and CNMs was not present on all labor and delivery units. Rather, beliefs informing birth philosophy influenced the presence of incivility and poor collaboration between CNMs and L/D nurses. Investigators defined this theme as the opinions, beliefs, and attitudes about birth that are widely held among professionals of a specific organization. These views may exist along a continuum, from a midwifery model view to a medical model view. Birth philosophies held predominately throughout a unit leads to groupthink regarding best practices and standards of care. Differing world views then results in conflict. One CNM captured this idea while elaborating about her experience at one facility, saying, “...the nurses weren’t receptive to the midwifery model. They were definitely under the ‘labor is dangerous and we’re
in charge…”’ World view and birth philosophy also determines other factors on a unit that may influence interactions between CNMs and L/D nurses.

**Policy imbalance.** Whether an organization supports the medical or midwifery model view of birth determines the leniency and adaptability of protocols for ensuring safe birth. Many CNMs report working in facilities that strictly regulate which aspects of their practice they can include in the care of a laboring woman. In a hospital setting, CNMs must adapt their practice and their patient’s wishes to comply with unit standards for practice. CNMs report that these limitations directly impact patient satisfaction and are a driving factor for them wanting to leave the hospital setting. One CNM stated, “if I got a patient up to the bathroom with ruptured membranes…we could be fired for that…or if we pushed a patient in the squatting position or on hands and knees, that was against the staff physician’s rules.” Policy development adapted to the medical model severely restricts a CNM’s ability to act as an independent provider. This leads to job dissatisfaction and is a barrier for inter-professional collaboration.

**Conflict expression.** In the data, labor and delivery nurses commonly self-identified as “patient advocates.” When hospital policies create strict requirements on what CNMs cannot do, labor and delivery nurses take on the role of identifying and reporting lapses in protocol adhesion. This is a major source of tension between CNMs and L/D nurses because it creates an environment of mistrust. Without standards in place for nurses to report concerns or breaches in protocol, ineffective communication between L/D nurses and CNMs results. Many CNMs reported feeling disrespected as the provider when confronted in the presence of a patient. One stated, “I’ve been questioned before in front of clients, which is not appropriate.” However, CNMs report feeling equally as insulted if the nurse chose to report the issue to a physician without first speaking with the midwife. One CNM stated, “…there were nurses who were
watching us in our rooms with the doors closed and were reporting back.” This environment of mistrust and the lack of clarity surrounding how to approach the situation is a barrier to positive relationships between CNMs and L/D nurses.

**Unit buy-in.** Healthcare is always changing, and medical professionals must be willing to change practice when new evidence is found. Resistance to change was a theme presented throughout the findings, relating to unit buy-in to the midwifery model view of birth. The dominating birth philosophy of a unit directly influences the unit’s ability to adapt to updates in best practice. In a unit with a medical model, beliefs about the superiority of electronic fetal monitoring (EFM) and interventional labor as well as misconceptions about midwifery practice trickle down to the level of the labor and delivery nurse and color their opinions and perceptions surrounding birth. This makes it extremely difficult for CNMs to fit into a unit’s culture and be respected as independent, competent providers. One CNM spoke for her midwife group as she reported going to extreme lengths to receive the approval of the doctors and nurses on the unit, saying, “We worked really hard at trying to change the culture and show the benefits of midwifery care to the nursing staff. So initially, we had meetings with them, and we bought them things…” Multiple midwives reported feeling the need to practice like doctors when first beginning on a unit in order to gain the trust of nurses and OBGYNs. “We didn’t do water births at first. We started with very small baby steps…you’ve got to go in there and practice like a doctor to get them to trust you.” This hostile work environment creates poor job satisfaction for the CNMs and is a barrier to positive relationships on L/D units.

**Experiencing roles.** Past and present experiences influence beliefs and knowledge. A repeated theme presented in the transcriptions was the idea that experience, or lack there of, influences attitudes and perceptions. Investigators defined this idea as experiencing roles, in
which personal and professional experiences inform one’s knowledge about the abilities, educational requirements, and scope of practice for various types of health care providers. Out of 28 participants, only six reported exposure to CNMs prior to working in obstetrics. For those six, three reported having a midwife as an instructor in nursing school, one reported knowing a midwife in her hometown, one used midwives for gynecological care, and one attended a friend’s home birth. The rest of the participants reported no interaction with midwives prior to becoming a labor and delivery nurse. They also testified to having misconceptions on what midwives did and many continued to show a complete lack of knowledge about the scope of practice of CNMs.

**Knowledge deficiency.** Twenty-four participants stated that they had no idea what a CNM was prior to working in obstetrics. Limited education surrounding advanced practice nursing degrees is provided during Bachelor of Science in Nursing programs, and none is provided as far as unit-specific education in nurse residency programs on labor and delivery units. Labor and delivery nurses are not educated regarding the scope of practice, education requirements, and outcome statistics of CNMs. As one nurse put it, “…nobody informed us what their scope of practice was…we had no idea.”

**Misconceptions.** The history of midwifery and variation in practice results in many misconceptions about CNMs’ qualifications and practice standards. Ten nurses reported believing that midwives only practice in birth centers or home births before working in labor and delivery. Four participants vocalized that midwives were only able to practice in low-risk birth settings, and believed that a transfer of care needed to occur when a patient became high risk. Both of these statements are untrue, and yet these are the beliefs still currently held by L/D nurses working side by side with CNMs.
Fear of poor outcomes. Experience in a variety of settings and with a variety of health care professionals creates fluidity in one’s beliefs. More than half of the CNMs interviewed reported working in a facility other than a hospital, while only one L/D nurse had experience in a birth setting where anesthesia was not readily available (see Appendix I). Working solely in a high risk setting biases one towards a fear of poor outcomes for either mom or baby. Fear of poor outcomes furnishes a resistance to change, again delaying unit buy-in and resulting in conflict among L/D nurses and CNMs.

Overlapping roles. A consistent idea verbalized by participants was the recurring similarities in job descriptions and responsibilities. When asked to describe one’s role in labor, nearly every participant reported being responsible for “ensuring safety” while also being a “patient advocate,” “support person,” and “educator.” Participants acknowledged the existing idea of role overlap, and openly attributed it as a predisposing factor for conflict.

Role ambiguity. When role boundaries are unclear, L/D nurses and CNMs are unsure of who should complete which tasks. As voiced by participants, this is a reason for ineffective team collaboration. CNMs reported assuming they were helping the nurses if they completed many of the tasks, feeling as though they were making the job of the L/D nurse easier. L/D nurses reported low job satisfaction when a CNM was present. One reflected on working with midwives, stating, “…it takes a lot of autonomy away from nurses. So if you’re the kind of person who wants complete control of your room or patients, then it can be kind of confrontational.”

Autonomy struggle. For many nurses, the similarities of roles between the advanced practice degree of the CNM and the BSN degree of the L/D nurse makes it difficult to regard the CNM as an expert in their field. As one nurse put it, “...you’re still basically a nurse. You just
have a little bit more certification…but we’re still kind of all equal.” Because of this lack of respect for the degree, many labor and delivery nurses feel as though they give up the aspect of control when working with CNMs, which is a part of their job they really enjoy. One nurse stated, “…there is an autonomy struggle when you’re working, depending on the midwife, that’s present for most of the labor…as a labor nurse, that’s what I get to do when working with physician’s.” While most advanced practice nurses take on an entirely new role after completing their graduate degree, Certified Nurse Midwives gain only the ability to prescribe, despite completing a two year program and having to pass a nationally qualifying exam. Overlapping roles creates an absence of professional boundaries, resulting in disrespect for the CNM as the primary provider and an autonomy struggle between two experienced health care professionals.

**Qualitative Analysis**

The demographic data between the L/D nurses and the CNMs was evaluated to ensure there were no major variations between the two groups. A table comparing the demographic characteristics can be seen in Appendix I. On average, the L/D nurses and CNMs in the sample were of about the same age and had nearly the same amount of nursing and perinatal experience. Differences between the two groups were that CNMs tended to hold higher degrees than L/D nurses and half of the CNMs had experienced birth outside of the hospital setting, while only one L/D nurse had perinatal experience in a setting where anesthesia was not readily available.

**Discussion**

There is a widespread misconception about the scope of practice, educational requirements, and abilities of Certified Nurse Midwives. America has one of the highest maternal mortality rates in the world, and is also one of the only countries using primarily OBGYNs as opposed to CNMs. In labor and delivery, CNMs consistently have higher rates of
patient satisfaction and lower rates of post-partum hemorrhages, pre-term delivery, and C-sections than OBGYNs (Benatar et al., 2013). CNMs are also capable of managing high-risk labor, despite the common belief that they are only skilled to work with low-risk patients. CNMs’ high rates of patient satisfaction and low intervention rates also mean larger profits for hospitals. This general lack of understanding surrounding the scope of practice and capabilities of CNMs leads to distrust and tension between CNMs and other healthcare providers, including L/D nurses. It also is one of the reasons that many organizational philosophies favor the medical model of birth.

In labor and delivery, electronic fetal monitoring is a means of reflecting fetal activity during pregnancy and birth. Tracking the fetal heart rate can give clues to how the infant is responding to the stress of birth. Because of this, EFM is an important piece of evidence when it comes to litigation in the event of an undesirable maternal or fetal outcome. Widespread fear of litigation has resulted in the development of hospital policies that rely heavily on EFM as a guide for when to intervene during labor. However, EFM is not indicative of fetal outcomes, and has not proven to be a reliable method for justifying intervention (Chez, Harvey, & Harvey, 2000). Because of this, many CNMs choose to use intermittent, rather than continuous, monitoring during labor to allow for non-pharmacological interventions for reducing pain such as walking or water birth. Current hospital policies have not been updated to reflect the current practice guidelines regarding EFM, nor have they been updated to allow for variation in practice between OBGYNs and CNMs.

With most advanced practice nursing degrees, there is a change in role description upon completion of the graduate program and certification exam. Midwifery is the only advanced practice degree that simply expands the role of a labor and delivery nurse, rather than changing it
entirely. While this leaves room for role ambiguity and can create conflict between the L/D nurse and the CNM, most nurses report that they enjoy working with Certified Nurse Midwives. Many noted that CNMs do a lot of the basic care, making the labor nurses’ job easier. Their patients also tend to be more education on the labor process and more prepared for their birth.

While investigators predicted that this would be a major barrier to a positive relationship between CNMs and L/D nurses, it seems that this only becomes an issue in the presence of a poor unit culture and conflicting world views. When unit policies are stringent and limit the independence of CNMs as providers, they also create tension between the L/D nurse and the CNM who share many roles in the care of the patient. As shown in Antevy (2017), effective team collaboration improves patient outcomes. Therefore, improving workplace relationships and reducing conflict between L/D nurses and CNMs could greatly improve both maternal and neonatal outcomes.

**Limitations**

There are several limitations to this study. First, this study used a convenience sample. Second, the data is specific to the Dallas Fort Worth area. Third, most of the data compiled was from individual interviews. Only one focus group was conducted, and the focus group produced a unique environment that allowed participants to feed off of each other’s ideas. Individual interviews may not have been as useful in eliciting the true feelings of L/D nurses or CNMs.

**Nursing Implications**

With consistent evidence supporting the fact that midwives have superior maternal and neonatal outcome statistics, education on CNMs’ is needed for all health care professionals. This education should cover the midwifery model, their scope of practice, their outcome statistics, and
the education required to become a CNM. This training should be provided not only in BSN programs, but also for hospital administrative staff and on all labor and delivery units.

BSN programs should also be adapted to reflect variations in care practices during the labor and delivery coursework. Nursing students are currently trained under the medical model, and this only further biases the perception of midwifery care once working on L/D units. By including clinical time in a birth center or in a hospital where midwives practice, students will be able to form their own perceptions on midwifery care during labor.

**Implications for Future Study**

This study prompted the need for further research on standing protocols in facilities with minimal reported conflict between L/D nurses and CNMs. As vocalized throughout the findings, organizational philosophy can greatly influence the ability of L/D nurses and CNMs to form positive relationships. Many hospitals are able to maintain an organizational philosophy that fosters collaboration between health care providers. Research looking into the policies and protocols at these hospitals should be studied because these protocols may be able to be applied to other hospitals to reduce conflict.
Appendix A

Figure 1: This model diagrams the attitudes and beliefs that inform actions and behaviors on labor and delivery units. Image adapted from Smit and Fritz (2008).
### Appendix B

#### Appraisal Chart of Evidence

<table>
<thead>
<tr>
<th>Authors</th>
<th>Type of Study</th>
<th>Strength of Evidence</th>
<th>Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen, D (2001).</td>
<td>Qualitative study</td>
<td>III</td>
<td>Good</td>
</tr>
<tr>
<td>Aquino, K., &amp; Thau, S. (2009).</td>
<td>Systematic review</td>
<td>IV</td>
<td>Good</td>
</tr>
<tr>
<td>Chez, B. F., Harvey, M. G., &amp; Harvey, C. J. (2000)</td>
<td>Systematic review</td>
<td>IV</td>
<td>Good</td>
</tr>
<tr>
<td>Dawley, K. (2003).</td>
<td>Literature review</td>
<td>V</td>
<td>Good</td>
</tr>
<tr>
<td>Demir, D., &amp; Rodwell, J. (2012).</td>
<td>Non-experimental study/quantitative descriptive</td>
<td>III</td>
<td>Good</td>
</tr>
<tr>
<td>Foley, L. (2005).</td>
<td>Qualitative study</td>
<td>III</td>
<td>High</td>
</tr>
<tr>
<td>Quance, M. A. (1997).</td>
<td>Qualitative study</td>
<td>III</td>
<td>Good</td>
</tr>
<tr>
<td>Raisler, J. (2000).</td>
<td>Literature review</td>
<td>V</td>
<td>High</td>
</tr>
</tbody>
</table>
NURSING CONSENT TO PARTICIPATE IN RESEARCH

Title of Research: Exploring the Working Relationship Between Labor and Delivery Nurses and Certified Nurse Midwives
Funding Agency/Sponsor: N/A
Study Investigators: Dr. Lisette Allender and Caroline French, Nursing Honors Student

What is the purpose of the research?
The purpose of this research is to explore the working relationship between L/D nurses and Certified Nurse Midwives.

How many people will participate in this study?
Up to 30 participants will participate in this study, but each focus group will contain only about 15 individuals.

What is my involvement for participating in the study?
As a participant, you will be asked to share your experiences and opinions on working relations between labor and delivery nurses (L/D nurses) and certified nurse midwives (CNMs).

How long am I expected to be in this study for and how much of my time is required?
This study will last for up to two hours in duration for either the focus group or individual interview.

What are the risks of participating in this study and how will they be minimized?
A potential risk in this study is the loss of privacy. The research team member will make every effort to keep all of your information private. A code number will be used to self-identify during the focus groups and on the questionnaires. All answers of the questionnaires and transcriptions will be kept on a computer that is password protected. Any paper copies of the questionnaires, transcriptions, and the codebook will be kept in a locked file cabinet in Dr. Allender’s office that only the researchers can open.

What are the benefits for participating in this study?
Potential benefits of this study are identifying the causes of reported incivility between L/D nurses and CNMs. Efforts can then be made to adapt the factors recognized to reduce this incivility, ultimately allowing for greater patient care and team collaboration for optimal patient outcomes.

Will I be compensated for participating in this study?
There is no monetary compensation for participating in this study. However, cookies and water bottles will be offered during the focus groups.

What is an alternate procedure(s) that I can choose instead of participating in this study?
This question is not applicable to this study because it is entirely voluntary and participants may choose to not participate or to withdraw at any point.

**How will my confidentiality be protected?**
A code number will be used to self-identify during the focus groups and on the questionnaire. Only the investigators will have access to the key for the code numbers, and this information will be kept on a password-protected computer. The answers to the questionnaire and the transcribed focus groups will also be kept on a password-protected computer. Any paper copies of the questionnaires, transcriptions, and the codebook will be kept in a locked file cabinet in Dr. Allender’s office that only the investigators can open.
You will not be identified by name at any point, as you will be assigned a code number to identify with.

**Is my participation voluntary?**
Your participation is voluntary. By signing this form, you are agreeing that you are taking part in this study because you want to. If you choose to not take part in the study, then nothing will happen to you as a result of your choice.

**Can I stop taking part in this research?**
You may withdraw from this research study at any time. If you do stop being part of the study, nothing will happen to you.

**What are the procedures for withdrawal?**
If you do wish to withdraw from the study, please contact the student researcher by notifying the student researcher, Caroline French at caroline.french@tcu.edu. There are no consequences for withdrawing from this study.

**Will I be given a copy of the consent document to keep?**
You will be given a copy of the consent document to keep after completion of the focus groups.

**Who should I contact if I have questions regarding the study?**
If you have any questions concerning my participation in this project, I will contact the student researcher: Caroline French at 425-736-2818 or email caroline.french@tcu.edu

**Who should I contact if I have concerns regarding my rights as a study participant?**
Dr. Dru Riddle, Chair-elect, TCU Institutional Review Board, Phone 817-257-6811
Dr. Michael Faggella-Luby, Chairperson, TCU Institutional Review Board, Phone 817-257-4355

Your signature below indicates that you have read or been read the information provided above, you have received answers to all of your questions and have been told who to call if you have any questions, you have freely decided to participate in this research, and you understand that you are not giving up any of your legal rights.

**Participant Name (please print):** ______________________________________________________

**Participant Signature:** _____________________________________________ **Date:** __________

**Investigator Name (please print):** _____________________________________ **Date:** __________

**Investigator Signature:** ______________________________________________ **Date:** __________
Appendix D

Focus Group Introduction Script

“Hello. My name is Caroline French and I am the student investigator from TCU Harris College of Nursing hosting this focus group with Dr. Lisette Allender for this study. Today, we would like to have a conversation with you about the working relationship between L/D nurses and CNMs. What we are trying to accomplish before we leave here today is to get a better understanding of the potential reasons for reported conflict. There are no wrong answers, just different points of view. You’ll notice that we are recording our discussion with our cell phones. This is so we can later review what we discuss today. Let’s go over some rules. First, let’s all turn off our cell phones so we are not interrupted. Please do not interrupt someone when they are talking. We need to ensure that only one person is talking at a time so that we can keep track of what people are saying. Of course, everything you tell us today will be kept completely confidential. Prior to speaking, always state your number to allow for anonymity. We will plan to combine the information we collect in this focus group with the other focus groups we conduct. One of my jobs today as the facilitator is to make sure we discuss all of the concepts we planned to discuss. If I ask you questions while you are talking, I am not trying to be rude; I am just making sure everyone has a chance to talk and that we cover all of the issues we plan to.”
Appendix E

Demographic Characteristics of Participants

- Age at time of survey (years)
- Years as practicing nurse
- Years of perinatal practice
- Indicate all nursing education levels completed
  - Diploma or associate degree
  - Bachelor’s degree
  - Graduate degree
  - Doctoral degree
- Which of the following classifications do you identify with?
  - Labor and Delivery Nurse
  - Certified Nurse Midwives
- Gender
  - Male
  - Female
- Ethnicity
  - African-American
  - Asian/Pacific Islander
  - White (non-Hispanic)
  - Latino or Hispanic
  - Native American
  - Other
• Participant or partner have given birth
  o Yes
  o No

• Acuity level of perinatal work setting
  o Level I
  o Level II
  o Level III
  o Level IV

• National Certification Completion
  o Inpatient Obstetric Nursing (RNC-OB)
  o Maternal Newborn Nursing (RNC-MNN)
  o Low Risk Neonatal Nursing (RNC – LRN)
  o Neonatal Intensive Care Nursing (RNC-NIC)
  o Electronic Fetal Monitoring (C-EFM)
  o Other (please explain)

• Have you ever worked in a birth setting other than a hospital?
  o Yes (please explain)
  o No
Appendix F

Focus Group Interview Schedule

1. How would you define your role in labor?

2. What is your philosophy on childbirth?

3. What was your experience with Certified Nurse Midwives prior to working in obstetrics?

4. What is it like to work with CNMs (or L/D nurses)?

5. Again, this study aimed to explore the relationship between L/D nurses and CNMs. Is there anything you feel that we have missed today?
Appendix G

Recruitment Post for Social Media

Attention – All Labor and Delivery Nurses and Certified Nurse Midwives in the DFW area:

You are invited to participate in a collaborative (IRB approved) research study conducted by Texas Christian University. We are requesting your participation to help us better understand the working relationship between L/D nurses and CNMs. Your response is critical to better understand what changes can be made to improve team cooperation and workplace stability. The research study is a focus group on TCU’s campus that will take no more than two hours of your time.

Please share this post with any other eligible L/D nurses or CNMs.

Thank you so much for your consideration and support. Please contact Caroline French at caroline.french@tcu.edu if you have any questions or are interested in participating.

Regards,
Caroline French, Student Nurse at Texas Christian University
Lisette Allender, Ph.D., MSN, RNC-OB
Appendix H

Email Response Script for Recruitment

Dear respondent,

Thank you so much for your interest in participating in our research study. First, I have a few questions for you to ensure you are eligible for the study:

1) Have you been working as a nurse in obstetrics for a year or more?
2) If you are an L/D nurse, have you had exposure to CNMs in your work environment?

The focus groups will be held on TCU’s campus in Bass Hall. Cookies and water will be provided. Further information will be provided closer to August regarding directions for parking and which room to report to.

Please let me know which date and time works best for you:

Wednesday, September 26th, 2018 at 7:30 PM. (CNMs only)
Monday, October 1st, 2018 at 4:00 PM. (L/D nurses only)
Saturday, October 6th, 2018 at 10:00 AM. (CNMs only)
Tuesday, October 9th, 2018 at 2:00 PM. (L/D nurses only)

If you aren’t available to meet at one of these times, let me know and we can schedule an individual interview at a time that is convenient for you.

Regards,

Caroline French, Student Nurse at Texas Christian University

Lisette Allender, Ph.D, MSN, RNC-OB
### Appendix I

#### Demographic Data

<table>
<thead>
<tr>
<th>Question</th>
<th>L/D Nurse</th>
<th>CNM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Range: 24-64</td>
<td>Range: 30-60</td>
</tr>
<tr>
<td></td>
<td>Average: 40</td>
<td>Average: 41</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td>Range: 2-41</td>
<td>Range: 4.75-35</td>
</tr>
<tr>
<td></td>
<td>Average: 12.5</td>
<td>Average: 17.46</td>
</tr>
<tr>
<td><strong>Highest Education Level</strong></td>
<td>Associates: 2</td>
<td>Associates: 0</td>
</tr>
<tr>
<td></td>
<td>Bachelors: 9</td>
<td>Bachelors: 0</td>
</tr>
<tr>
<td></td>
<td>Graduate: 4</td>
<td>Graduate: 9</td>
</tr>
<tr>
<td></td>
<td>Doctoral: 0</td>
<td>Doctoral: 4</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>White: 13</td>
<td>White: 11</td>
</tr>
<tr>
<td></td>
<td>Latino: 2</td>
<td>Latino: 1</td>
</tr>
<tr>
<td></td>
<td>African American: 0</td>
<td>African American: 1</td>
</tr>
<tr>
<td><strong>Experience in Birth Setting Other Than Hospital</strong></td>
<td>Yes: 1</td>
<td>Yes: 7</td>
</tr>
<tr>
<td></td>
<td>No: 14</td>
<td>No: 6</td>
</tr>
</tbody>
</table>
References


doi:10.1016/j.sbspro.2009.01.160


doi:10.1146/annurev.psych.60.110707.163703


