DISCOVERING THE ROLE OF THE LABOUR AND DELIVERY NURSE

BY

MARGARET A. QUANCE

A Thesis

Submitted to the Faculty of Graduate Studies

in partial fulfilment of the Requirements

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Abstract

Midwives are becoming accepted as legally sanctioned health care providers in Canada. In Manitoba, the impact of midwifery on the role of the labour and delivery (L&D) nurse is unknown. The role expectations of the midwife are well described in the literature. The role expectations of the L&D nurse have not been as well described - indeed, the role expectations of the generic nursing role are not well understood, within or without the profession. The purpose of this study was to describe the perceived role expectations and role performance of L&D nurses in Winnipeg, and the perceived factors affecting role expectations and performance. This was facilitated through the use of the conceptual frameworks of role theory and organizational culture. L&D nurses had clear views of their role expectations and role performance; there was no role ambiguity. Role expectations demonstrate considerable overlap with midwife role expectations in the literature. Perceived role performance emphasized the importance of psychosocial support to women and families. This is contradicted by other research. Factors affecting role expectations and role performance were many, including staff relationships, health care reform, and nursing administration. The philosophical model of birth L&D nurses described was more of a medical model than the midwifery model. This may prove to be the greatest source of conflict between midwives and nurses.

Chapter 1 Statement of the Problem

Labour and delivery nurses in Manitoba "know" what their job entails. They are aware of what needs to be done, what is required to do the job and how to go about getting it done. To date, L&D (L&D) nurses' perceptions of their role expectations and role performance have not been explicated.

In Canada, there has been progressive movement toward the incorporation of the midwife into the health care system as a health care provider. Ontario leads the movement as midwifery is now a recognized profession with an established College of Midwives. Ontario is the only province presently offering midwifery education as a four year baccalaureate program (Burgin, 1994; "President's Address", October, 1994).

Midwifery was recognized as a health care profession in 1992 in Alberta (Burgin, 1994). A report, submitted by the Alberta Association of Midwives to the Canadian Confederation of Midwives in June, 1997, indicated the earliest date that the first midwives are expected to be licensed is by Fall, 1997. However, there are significant barriers that may impede the practice of midwifery. The Minister of Health has announced that there will be no allocation of funds for midwifery services. Each region will decide whether it will fund midwifery services, but the funding must come from existing budgets. Other implementation issues, such as admitting privileges, are also at an impasse as there is reluctance to proceed with no allocated funding (Alberta Association of Midwives - "Report to the Canadian Confederation of Midwives (C.C.M.)", June, 1997).

British Columbia's government legalized midwifery practice in 1993 with the first College of Midwives established in 1995 (Burgin, 1994; "B.C.'s First College of

Midwives Established", 1995). The College of Midwives of British Columbia sent out a call for applicants in the Spring, 1997. Applicants will be notified of successful registration by the end of 1997. Implementation planning is well advanced, though there are still funding issues to be resolved with the Ministry of Health ("Midwives Association of British Columbia Annual Report to the Canadian Confederation of Midwives", June, 1997).

Quebec has had a long-standing midwifery maternity service in Povungnatuk and seven pilot projects in free-standing birth centres located throughout the province. However, the expansion and legalization of midwifery has foundered on the shoals of strong medical opposition, and disorganization and dissention between lay and nurse-midwifery groups (Burgin, 1994). Legislation establishing midwifery as a profession is expected to be introduced in September, 1998 ("Le Regroupement Les Sages Femmes du Quebec Annual Report, 1996-97, for the C.C.M.").

In other areas of the country, governments have been slow to recognize midwifery as a profession. There are lobbying efforts continuing in Saskatchewan, Newfoundland and Labrador, Nova Scotia, and the Northwest Territories ("Association of Nova Scotia Midwives Provincial Report to the C.C.M., June 1997"; "Midwives Association of Saskatchewan 1997 C.C.M. Report"; "Newfoundland and Labrador, Report to C.C.M., May 1995"; "Northwest Territories Report, May, 1995").

The Manitoba government has implemented a health reform program for all aspects of the health care system. Some of the major objectives of the program, as outlined in the document Quality Health for Manitobans: The Action Plan (1992), include eliminating duplication of services, movement of health care from institution-centred to

community-centred bases, and cost effectiveness. Midwifery care is an option pursued by government in its health reform quest. Midwifery, in its broadest practice scope, is community-centred, and focussed on health promotion for child-bearing families and well women (Avery & DelGuidice, 1993; DeVries, 1989). Midwifery has been demonstrated to be cost effective in the United States (Schlatter, 1991). Midwifery care has also been demonstrated to be safe, as it provides as good if not better outcomes for low-risk mothers and babies than does physician-provided care, through a more passive and less interventionist approach (Avery & DelGuidice, 1993; Buhler, Glick, & Sheps, 1988; DeVries, 1989; Ernst, 1996; Haire & Elsberry, 1991; Kaufman, 1992; Klein, Lloyd, Redman, Bull, & Turnbull, 1983; Rooks, Wetherby, Ernst, Stapleton, Rosen, & Rosenfield, 1989; Scupholme, McLeod, & Robertson, 1986).

In 1992, the Manitoba Government, in response to consumer demand and an active midwifery lobby, appointed a Working Group to determine whether and how midwifery should be implemented. This group submitted a report to the government early in 1993. The report recommended the establishment of the profession of midwifery, as a direct entry profession, rather than as a specialty of nursing, a nurse-midwife (Women's Health Branch, 1993). In April, 1994, the government announced its intention to legalize midwifery and established the Midwifery Implementation Council (M.I.C.). The Council had a mandate to complete recommendations for education, legalization, practice guidelines, assessment of skills and upgrading of midwives and practitioners with midwifery preparation and/or experience. Bill 7 - the Midwifery and Consequential Amendments Act was passed in June, 1997 (F. Klassen, personal communication, July 25, 1997). It is expected to come into full effect within a year after passage ("Midwifery

Implementation Council, Manitoba: Update, May 28, 1997").

Historically, nurses have influenced the development of the role of the midwife in Canada. In the late 1800's, the Victorian Order of Home Helpers was envisioned as a method by which women would receive training in midwifery and first aid, and provide these services within their own communities (Mason, 1987). Nursing was not as well established as a profession, and both nursing and physician groups saw home helpers as a threat to their livelihoods. They effectively lobbied Lady Aberdeen and the National Council of Women to redefine and rename the order to the Victorian Order of Nurses. Only trained nurses would be employed, subject to physician supervision and direction (Mason, 1987; Pringle, 1988).

Nursing has attempted to impact the developing role of the midwife in Manitoba, through position statements (Manitoba Association of Registered Nurses (MARN), 1990; Manitoba Nurses' Union (M.N.U.) Handbook, 1994). Nurses were part of the membership of a committee of the College of Physicians and Surgeons which made recommendations for midwifery practice (Report of the Future Role of Midwifery in Manitoba, 1991). These documents advocate a nurse-midwife model rather than a direct-entry model. Nurses were appointed to the Working Group on Midwifery and the M.I.C., and continue lobby efforts individually and through groups such as the Association of Manitoba Midwives. Most of the appointed nurses are also midwives who have received their education in Europe or other Commonwealth countries.

One effect of the nursing lobby has been conflict between lay midwives and nurse-midwives. This conflict was identified by Burgin (1994) as a stumbling block to the legalization of midwifery. Conflicting interests persist, as evidenced by a separate

organization for each group. Although the nurse-midwife group changed its name from the Manitoba Association of Nurse-Midwives to the Association of Manitoba Midwives, its membership is still exclusively nurse-midwives (F. Klassen, personal communication, Sept. 28, 1995).

The impact of the midwife upon the practice of L&D nurses is unknown and will depend significantly upon the scope of practice allowed the midwife. However, some idea can be gained by comparing the roles the midwife and the L&D nurse occupy in the provision of care to mothers and babies. The role of the midwife is well-defined in the literature, both in general terms (Definition of Midwifery, Appendix 1) and specifications of specific tasks (Avery & DelGuidice, 1993). The American College of Nurse-Midwives (ACNM) has collected statistics over a number of years documenting practice patterns (Adams, 1984; Avery & DelGuidice, 1993; Haas & Rooks, 1986; Lehrman & Paine, 1990; Walsh & Boggess, 1996; Walsh & DeJoseph, 1993). The role of the L&D nurse is not as well documented, nor studied, and therefore, is not clearly defined. Only the Nurses' Association of the American College of Obstetricians and Gynaecologists (NAACOG) (now Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)) Standards (1991) give formal guidelines for nursing practice in this clinical area. These standards describe the ideal role of the intrapartum nurse. They do not describe the actual role or job of the L&D nurse, nor how she perceives her care. It is not known how much overlap there is between the role of the midwife and the role of the L&D nurse. It is not known what philosophical beliefs guide the care provided by nurses. Chaska and colleagues (in press) suggest staff nurses may be influenced more by the expectations of physicians than by those of nurses in relation to professional practice. It

is not known where nurses lie on the continuum between the medical (interventionist) model of birth and the midwifery (non-interventionist) model of birth.

The creation of a new health care provider in the person of the midwife, whatever her educational preparation and scope of practice, will undoubtedly cause major, perceptible effects. Conflict, covert or overt, may result (Strohbach, 1991). Such conflict is described by Watson-Lubic (1994). She describes nurse-midwives who attempt to ignore or denigrate their nursing preparation, so as not to be perceived as being in the traditional handmaiden role. Nurses have been observed characterizing midwives as "...'baby catching technicians'. When asked by nurse-midwives to assist with the nursing care of labouring families, nurses have been heard to retort 'You're a nurse; do it yourself'" (p. 2). Nurses may feel their jobs will be threatened. They may feel the midwife is a more "elite" practitioner, possibly receiving higher remuneration, with more authority over patient care matters, increased educational opportunities, increased job variety (in provision of antepartum, intrapartum, and postpartum care), and with more opportunity to develop collegial relationships with physicians. Perinatal nurses may feel "...they may become handmaidens to yet another professional group, being expected to take orders from midwives and having to do their 'dirty work'" (James, 1993, p. 914). Nurses may perceive midwives as competition; nurses and midwives could be doing the same job.

Studies examining sources of stress and factors influencing job satisfaction lend weight to the possible reaction of nurses to the introduction of midwives. Chaska (1992), in her review of research conducted on the staff nurse role, lists role strain as one of three dominant problems related to role enactment. Ward (1986), Tri (1991), Taristano,

Borphy & Snyder (1986), and numerous others have implicated role ambiguity as a source of job dissatisfaction and a reason for nurses moving to different nursing jobs, or even leaving nursing (Kramer, 1974). Conflict and poor interpersonal relationships following introduction of different systems of care with different role expectations have been described in the literature (Chimner & Easterling, 1993; Macleod & Sella, 1992). It is vital to describe the role of the L&D nurse to ascertain whether there might be role overlap with the described midwife's role, that could contribute to role strain, role conflict, or job dissatisfaction from the nurse's perspective.

Problem Statement

The purpose of the study is to discover the nurse's perceptions of role expectations and role performance in the L&D setting. Specific research questions are:

1. What does the L&D nurse perceive her/his role expectations to be?

2. How does the L&D nurse perceive the actual work of the nurse in this setting (role performance)?

3. What organizational and/or unit factors does the nurse perceive as affecting the her/his ability to do the job the way the she/he would want to do it?

4. What philosophical beliefs does the L&D nurse hold about the birth process?

Chapter 2 Conceptual Framework

The conceptual frameworks used to ground this study are role theory and organizational culture. Role theory explains and defines what the nurse believes, and how he or she behaves. Organizational culture explicates and groups the variables that affect and impact the role of the nurse. A series of definitions will follow that will explain the various elements of the conceptual frameworks.

- Role theory: a "study of behaviours that are characteristic of persons within certain contexts and with various processes, that presumably produce, explain or are affected by those behaviours" (Biddle, 1979, p. 4).
- Role expectations: idealized attitudes and behaviours of a particular social position within society, in this case, the L&D nurse. The nurse has certain expectations of herself and of others in this role (Biddle, 1979; Chaska, 1978; Hardy & Hardy, 1988).
- Role performance: the actual attitudes and behaviours of the person filling the role, in this case, the L&D nurse role (Roberts, 1983).
- Perceptions: "...a view of performance of oneself or others, past or present" (Chaska, 1978, p. 357). Perceptions of role expectations of the L&D nurse express what the role should be like. Perceptions of role performance express what the role is like.
- Role ambiguity: occurs when the expectations within the role are incomplete or insufficient to guide behaviour (Biddle, 1979, p. 393).
- Role stress: "...A social structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet" (Hardy & Hardy, 1988, p.

76).

- Role differentiation: exists when two roles have few behaviours in common (Biddle, 1979).
- Role overlap: exist when two roles have few behaviours that are different (Biddle, 1979).
- Role conflict: a condition in which existing role expectations of a role are contradictory (Hardy & Hardy, 1988).
- Organizational or unit culture: measurement of common thoughts, behaviours and beliefs peculiar to an organization or a unit (Flarey, 1993; Thomas, Ward, Chorba & Kumiega, 1990).
- Cultural elements (or behaviours): elements that impact on the culture of the organization or the unit. Such elements may include power relationships, support systems, groups preferences for stability versus change, policies and procedures, common practices and the type of governance system in place (Coeling & Sims, 1993; Flarey, 1993; Sullivan & Decker, 1992; Thomas et al., 1990).
- Organizational or unit climates: the individual perceptions or feelings about the organization or the unit. These feelings or perceptions are dependent on social and physical components (Flarey, 1993; Thomas et al., 1990).

Figure 1 illustrates the conceptual framework developed for this study. Role expectations and role performance overlap. This acknowledges the impact of role expectations on the role performance of the nurse. Role performance may, in turn, modify the role expectations of the nurse. The amount of overlap for each nurse will differ. It will depend on the impact role expectations and role performances have upon

each other. The greater the overlap, the greater the congruity between role expectations and role performance for the individual.

There are three variables seen to influence the role expectations of the L&D nurse: professional standards, formal education, organizational culture. Role expectations are formally developed by professional bodies such as the Manitoba Association of Registered Nurses (MARN), AWHONN, and formal education programs (Biddle, 1979).

Organizational culture has a major impact on the nurse's role expectations. Mitchell (1994) points out that when a nurse accepts a position in an institution, "that nurse is seen as making a commitment to the value system of that organization and/or unit" (p. 958). Organizational culture includes the following elements: the job description, levels of acuity (tertiary, secondary, or a primary care unit), presence of medical resident staff, the number of obstetrician versus family physician performed deliveries, intervention rates (for Caesarean sections, epidurals, and forceps), and the formal orientation process for the nurse. Taunton and Otteman (1986) note that job boundaries are influenced by policies and procedures, and that this, too, helps shape the nurse's role.

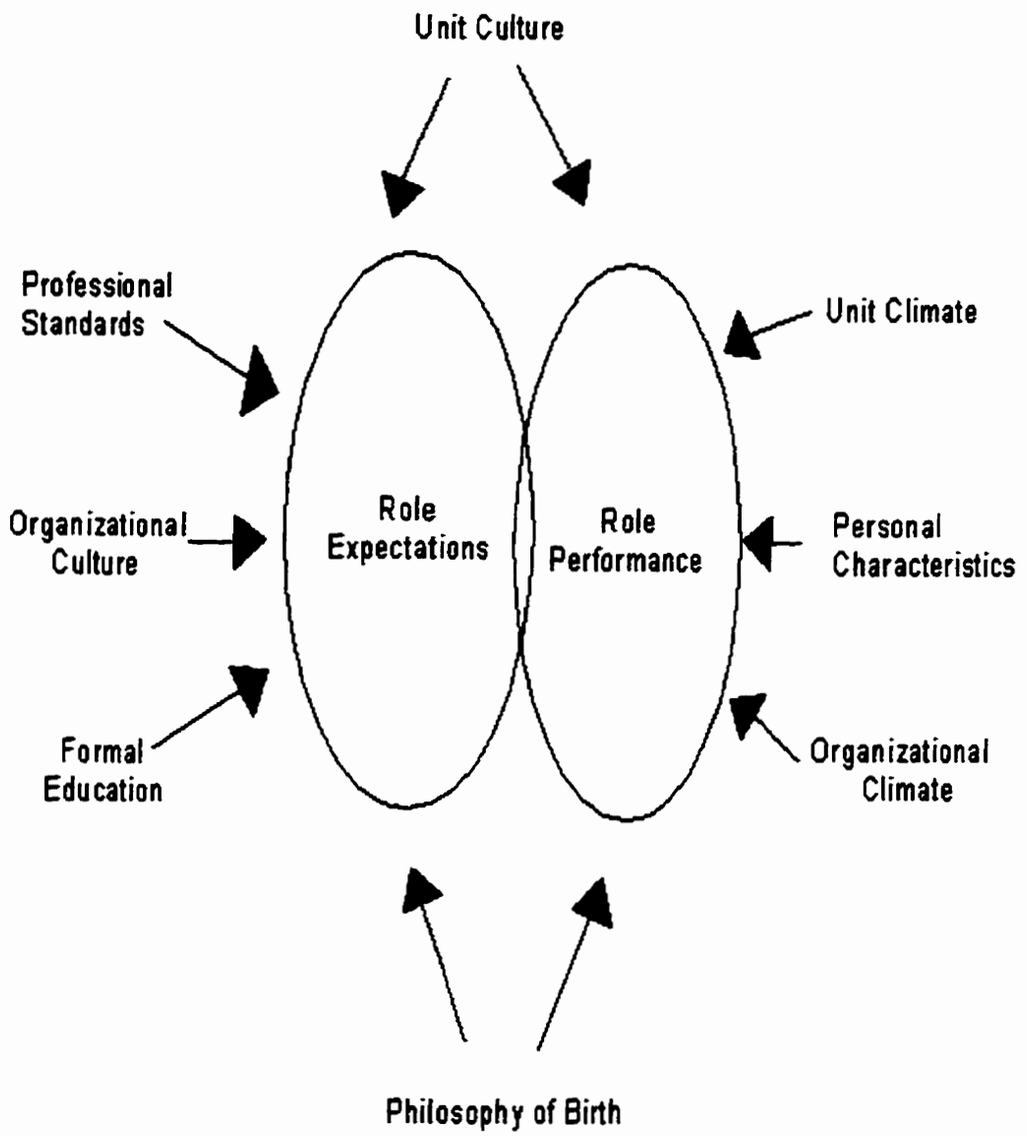


Figure 1: CONCEPTUAL FRAMEWORK

Medical practice styles, as an element of the organizational culture, may be a factor influencing the nurse's role, although this is not mentioned in the literature. This is a factor that may have great impact, as one of a nurse's responsibilities is to carry out physician orders. A physician may believe in the benefits of Syntocinon augmentation regardless of how long the membranes have been ruptured. The nurse is generally obliged to carry out such an order, even if the nurse holds the view that this is unnecessary and that nature will take its course. After some time, the nurse may gradually begin to accept the physician's approach as the correct method. Her/his role expectations will have changed. Chaska (1992) cites preliminary data from a study indicating staff nurses may be more influenced by physician expectations than by those of other nurses. Sandelowski (1988) states "The nurse is becoming more like the physician who touches the patient primarily to obtain information" (p. 43). This is antithetical to the basic tenet of nursing which aspires to holism and connection (Sandelowski, 1988).

Variables seen to impact more specifically on role performance are organizational climate and unit climate. One insight into the organizational climate will be the turnover rate in the unit. A low turnover of staff may indicate a group of satisfied nurses. In these days of health care reform with bed closures, resulting in nurse lay-offs, this may not be the case. A high turnover may be reflective of the unsettled environment, rather than organizational climate. Unit climate may be defined as the individual perceptions of the nurses about "their" unit. This may be measured by asking, for example, about the informal leaders within the unit, the perceived effectiveness of the formal leader, and what problems they can identify with "their" unit. Unit climate may also include nurse - nurse relationships and physician-nurse relationships. Physician-nurse relationships have

been identified as a source of stress and job dissatisfaction in the literature, as have poor peer relationships, and perceptions of autonomy and powerlessness (Bush, 1988; Gray-Toft & Anderson, 1981; Haydon, Davis & Clore, 1982; Hipwell, Taylor & Wilson, 1989; Tri, 1991; Tumulty, Jernigan & Kohut, 1994; Ward, 1986).

Role performance is also affected by the personal characteristics of the nurse, such as age, gender, basic nursing education, years of nursing experience, position held, and the length of employment at the institution. Bircumshaw and Chapman (1988) identify possible influences on practice style such as age, sex, level of education, amount and type of experience in nursing, the type of basic nursing education program, personality and position. One could also add institutional policy and procedures, peer relationships and physician-nurse relationships.

Many variables may affect the nurse's role expectations, and thus her role performance. It makes intuitive sense that some variables affecting role expectations will impact on role performance, and variables affecting role performance may change role expectations. For example, a nurse working in a community hospital setting depends largely on her own assessments and makes decisions with minimal input from physicians. She or he acts in an autonomous fashion. This may occur because there are no medical residents. When the same nurse is employed at a tertiary care institution, where resident staff is available, she or he will continue to act in a more autonomous manner because that is a self expectation. It usually will take an incident where the nurse's behaviour is corrected (ie. s/he should have consulted with the resident) before her/his role expectations and, subsequently, behaviour (role performance) change. Two variables affecting both role expectations and role performance are unit culture and personal

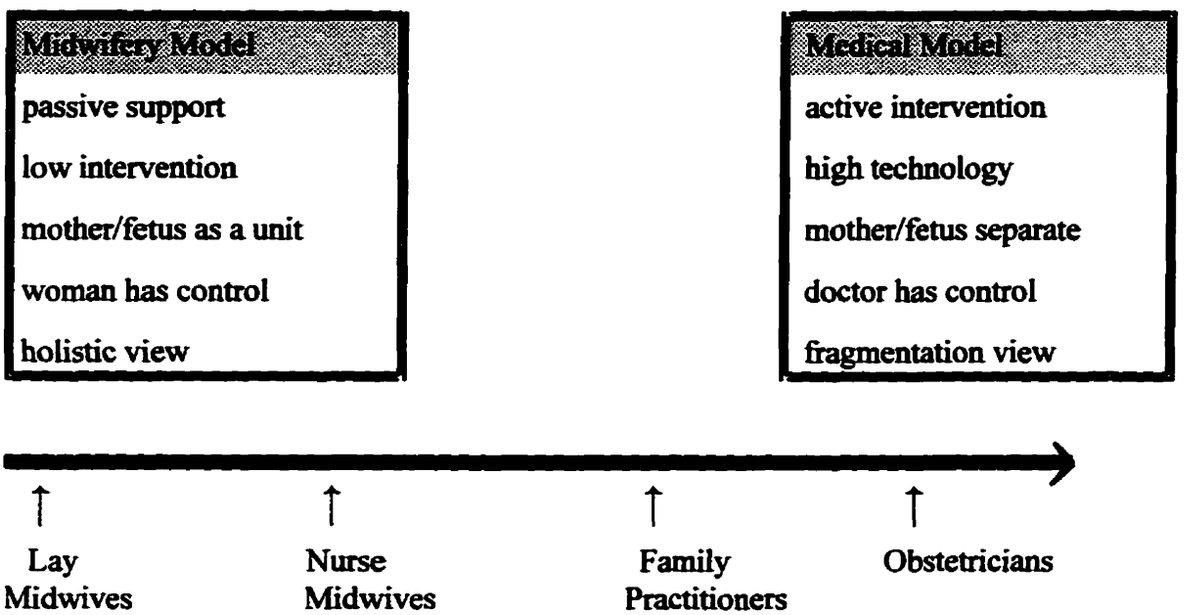
philosophy of birth. It is difficult to determine whether they have more effect on role expectations or role performance. This is the reason they are located equidistant between role expectations and role performance.

Role expectations are developed by elements within the unit culture. Thomas et al. (1990) go even further, stating that different cultures may exist between different shifts on the same unit. Personal experience of the investigator, gained through employment in three of the five L&D units in Winnipeg, has reinforced the idea that each nursing unit has its own culture. Examples of unit culture include the hierarchy within the unit, the nurse-physician relationships, relationships with nursing colleagues, relationships with the consumer, and the expressed unit philosophy regarding the birth process. Kramer (1974) discusses in detail the methods used by nursing staff to socialize the new graduate into "our way" of providing nursing care. The influence and importance of unit culture are illustrated in Dabney's (1995) study examining drug diversion and/or use among nurses. There was work group acceptance of deviant behaviour of theft of general supplies and over-the-counter medications. As Dabney stated, "Among the nurses in this study, it appears that the formal work group norms routinely take precedence over formal hospital policies" (p. 53).

Another important factor affecting role expectations is the nurse's beliefs or philosophy about the birth process. The nurse's philosophy gives her/his care direction. It creates inner expectations as to what processes and events should occur, or what will constitute "normal" or "abnormal". A philosophy may develop in a variety of ways; through formal education programs, and/or experience, and interaction with colleagues. The midwifery or holistic model views pregnancy and birth as a normal process, and part

of the life-cycle. The holistic, integrating approach sees the woman maintaining responsibility and control over her body and her care. Mother and baby are an inseparable unit. Labour pain is acceptable and normal. Interventions for birth are minimal and passive, directed at supporting and encouraging the mother throughout the process (Annandale, 1987, 1988; Avery & DelGuidice, 1993; Buhler, 1996; Davis-Floyd, 1992; DeVries, 1989; Graham, 1991; Lichtman, 1988). The medical or technocratic model, in contrast, shifts the focus of responsibility and control from the woman to the physician. A classifying, fragmenting approach is used. The baby is the product; the mother is viewed as the means by which the baby arrives. Labour pain is unacceptable and problematic, therefore needing to be controlled. The pregnancy and labour process is viewed not as a natural event, but rather as a potential disaster. Intervention is mandatory, to "prevent" the unexpected from occurring (Buhler, 1996; Davis-Floyd, 1992; DeVries, 1989; Graham, 1991; Lichtman, 1988; Queniart, 1992).

Figure 2: Midwifery (Holistic) and Medical (Technocratic) Models As Polar Opposites Along a Continuum



The midwifery and medical models, as illustrated in Figure 2, are seen as polar opposites along a continuum. In his description of the four types of birth care providers found in the United States, DeVries (1989) provides valuable information that assists with the placement of these providers along the continuum. The four groups of care providers are lay midwives, nurse-midwives, family physicians, and obstetricians. Nurses are not included in his discussions. Although he does not address this omission, it is probably because nurses have a supportive role only, and do not make the decisions to order this treatment or that therapy. The nurse does not have that authority.

Lay midwives are often "called" to midwifery after observing a home birth or having a home birth themselves. Training of lay midwives is usually a combination of

self-education and apprenticeship. This type of training supports a holistic view of birth that emphasizes the spiritual, naturalistic elements of birth. Lay midwives believe "the body is capable of giving birth with little or no outside intervention" (DeVries, 1989, p. 148). When interventions are required, they are "natural". For example, "...to stimulate labour, they give their clients raspberry or cohosh tea rather than oxytocin" (DeVries, 1989, p. 148-149). There is often a sceptical attitude toward organized medicine.

Nurse-midwives, DeVries (1989) states, have a much more scientific approach to birth because their knowledge is acquired in a medical setting, and is taught in a fragmented manner (physiology, pharmacology, and so on). During the educational process, they are socialized into the belief that birth has dangerous elements to it. Interventions may be necessary. Nurse-midwives see service to birthing women as a means to make a living rather than as a calling (DeVries, 1989). Reliance upon and interdependence with physicians is required through the mechanism of consultation.

The family physician has a greater sense of holistic care than does the obstetrician, as he/she may care for the whole family, rather than just the pregnant woman. As DeVries (1989) states, "Given these characteristics, birth is likely to be viewed as natural and a normal event" (p. 153). This view of birth does anticipate intervention because of the nature of and socialization to "science" in their medical training. Family physicians know what range of interventions are available for the woman, and can provide many of them. For the more advanced technology (eg: certain kinds of forceps, Caesarean sections), the family physician must rely on the obstetrician.

The obstetrician is the expert in the pathologies of pregnancy and birth. This professional has the ability and training to provide the most advanced technology to the

problems that arise with birth. But, as DeVries (1989) cautions, "Heroic techniques are applied to women and babies who do not need to be rescued" (p. 154). He also states "...the more the specialized knowledge of the caregiver increases,...the more the power of the client decreases" (p. 154). This is in sharp contrast to the relationship of the lay midwife to the client. The lay midwife is invited into the client's home and must respect her wishes. "The client who enters the hospital is a guest of the practitioner and is less able to direct her care" (DeVries, 1989, p. 152).

Thus, it can be seen that the providers of birth care can be placed on a continuum from passive support to active intervention, from a holistic view to a fragmented view, from the woman maintaining control, to the physician having control.

In conclusion, the conceptual framework is grounded in role theory and organizational culture. Role expectations and role performance are seen as intersecting circles, each impacting on each other. Variables are identified that influence role expectations and role performance. Two variables, unit culture and philosophy of birth, are seen as affecting both role expectations and role performance. This conceptual framework provides the structure on which the research design is based.

Chapter 3 Literature Review

It has been stressed many times throughout the years by many authors that nursing's role as a health care provider is ambiguous and confusing. Singleton & Nail (1984) deplore the diffusion of nursing's role to other health care provider groups such as social workers and patient educators. They quote Rademaker: "If nurses do not define a clearly understood role, they may have difficulty maintaining their precarious professional status because they have not demonstrated that they possess a unique set of skills" (p. 17). Role clarity and role differentiation for nursing would not only heighten nursing's professional status, but improve staff morale, job satisfaction, commitment to the organization and profession, as well as increase the autonomy of the nurse (Chaska, 1990; Forrester, 1985; Fried, 1988; Katzman & Roberts, 1988).

For this literature search, several computerized programs were utilized. These included Cumulative Index Nursing and Allied Health Literature (CINAHL), Medline Professional, Psychlit and Sociofile. Key words used included nurse role, role stress, role strain, role expectations, role conflict, role theory, L&D nurse role, perinatal nursing, intrapartum nursing, midwifery, nurse-midwives, relationships, physician-nurse relationships, nurse-midwife relationships, birth philosophy, nursing practice, to mention but a few. This search proved largely fruitless in finding articles describing role performance of the L&D nurse, or research describing role conflict between nurses and midwives. The final step was to utilize a hand search of related articles in the journals.

The Generic Nursing Role

The literature review will review the generic nursing role, comparisons of role expectations of the L&D nurse and the midwife, the consumer's perspective of the L&D nurse role, quantitative studies examining nurse support in labour, and role conflict between the L&D nurse and the midwife.

The role of the L&D nurse has been described in the literature, but only in very broad terms. A basic nursing text outlines four aims of nursing: promoting wellness, preventing illness, restoring health and facilitating coping. The authors further delineate three categories of independent nursing actions: dependent nursing actions, interdependent nursing actions, and independent nursing actions (Taylor, Lillis & Lemoine, 1989). Other authors see nurses as interested in the human aspects of health care, such as health education, disease prevention and, again, facilitating coping (Stein, Watts & Howell, 1990). Simpson (1989) takes a different approach, describing the nurse as manager and coordinator of care of patients and families. The American Nurses Association identified core components of all nursing practice: 1) nursing (eg: assessment, direct care), 2) teaching, supervision and delegation of nursing practice, and 3) execution of the medical regimen (Mechanic, 1988). The generic roles the nurse fulfils are those of caregiver, communicator, teacher, counsellor, leader, researcher, and advocate (Bobak, Jensen & Zalar, 1989; Taylor, Lillis & Lemoine, 1989).

There is a body of research that has attempted to define the generic role expectations of the nurse. Weiss (1983) found that no unique nursing domain emerged from 20 months of directed dialogue between a selected group of nurses, physicians, and consumers. There was also lack of clarity within the nursing profession of its specific

role in health care, and consumers perceived nurses as physician extenders. Another study (Stern, Stroh, Fisher, Cromwell, McCarthy, & Prince, 1991) reinforces this finding in the setting of a pediatric intensive care unit. There was a difference between physicians' perceptions of nursing roles and nurses' perceptions of nurses' roles. The roles under examination were communication and decision-making. Physicians felt nurses contributed far less frequently in these areas than did nurses. Ellefsen (1992) conducted a qualitative study in an attempt to define the role of the community nurse health officer in Norway. This nurse functioned as a gate keeper for access to community health nursing services, and here again, role ambiguity was a major factor. The community nurse health officers felt they were being expected to translate vague national and municipal goals for care into specifics, with little direction as to how this should be accomplished. The role expectations were affected by ambiguous government policy.

A number of studies have examined specific factors that affect the perceptions of the nursing role, for nurses and physicians. Forrester (1988) examined sex role identity on perceptions of nurse role identity. He defined nurse role discrepancy as the "disparity between the idealized conceptions of the nurse role and perceptions of actual enactment of that role" (p. 600). Nursing roles were categorized as the professional, bureaucratic, or service role. He concluded that sex role identity did not contribute to nurse role discrepancy, but discrepancies did exist.

Chaska, Clarke, Rogers and Deets (1990) examined the effect of status consistency on nurses' and physicians' expectations and perceptions of the staff nurse role. From the data analysis, she ultimately concluded the staff nurse role is ambiguous in the independent, dependent, and interdependent aspects, both within and between the

nurse and physician groups. Chaska's study reaffirms the ambiguity of the generic nurse role, but her study is very esoteric, particularly with regard to the concept of status consistency. The meaning of status consistency remains unclear. Simplifying terms and concepts would have facilitated evaluation of the merits of this study.

Katzman (1989) examined the issues around nursing authority and power as viewed by nurses and physicians. The important finding in this study, pertinent to the perception of nursing roles, is that physicians and nurses vary greatly on their perceptions of what nursing authority is and should be. Physicians perceived nurses as currently having less authority, even over such items as nursing standards of care, yet nurses perceived themselves having more authority. Katzman and Roberts (1988), in a qualitative study of physician and nurse practitioner interaction, found that social roles and sexual roles (male dominant, female submissive) affected the enactment of the nurse practitioner role. This finding is in contrast to that of Forrester (1988), discussed earlier, who found that sex roles did not play a role.

Taunton and Otteman (1986) and Kinney (1985) both refer to and studied the multidimensional aspect of the nurse role. Kinney reasoned that strictly limiting the nursing role to bureaucratic, professional and service categories is too simplistic. Dependent upon the clinical unit, the situation, the age, and personality characteristics, the nurse may slip from one role to another to best meet her patients' needs. Kinney determined that sex typing, ego development and assertiveness did not affect the role or combination of roles that nurses utilized. Taunton and Otteman (1986) developed an empirically based staff nurse role conception and found seven major components that contained 12 different dimensions. Unfortunately, the authors do not clarify what the

dimensions are and how they relate to the components. The seven components of role conception (role expectation) include: 1) professional boundaries, 2) job boundaries, 3) direct patient care services, 4) authority relationships, 5) autonomy, 6) ethics, and 7) billing costs. The first five components were found to be more "potent", and job boundaries, direct patient services, authority relationships, and ethics were determined to be multidimensional. "Multidimensional" referred to the "filters nurses used to make decisions about what they would do in a given day's work" (p. 33).

The research can be said to be inconclusive in determining what a generic nursing role is, and if anything, reinforces the multitude of elements and factors that make up and affect the nurse's role. It is not surprising, then, that the L&D nurse's role expectations have not been specifically described when there has been so much difficulty describing the generic nursing role.

Comparisons of Role Expectations of the L&D Nurse and the Midwife

Hospitals providing obstetrical services in Winnipeg were polled to ascertain whether there were specific job descriptions for L&D nurses. Such documents could be expected to spell out the role expectations for the L&D nurse. All hospitals were found to use generic job descriptions that would apply to all nurses in the institution, irrespective of the clinical setting (See Appendix B for job descriptions). The Victoria Hospital titled its job description "Labour and Delivery Nurse". However, the nurse manager verified that the contents of the job description were exactly the same for all nursing units (D. St. Claire-Ince, personal communication, September 28, 1995). All job descriptions have common elements that correspond to generic roles identified by nursing

textbooks (Taylor, Lillis, & Lemoine, 1989; Bobak, Jensen, & Zalar, 1989).

The Victoria Hospital's job description was developed in 1993, and is the briefest of all five hospitals. Nurses are required to work with and accept the Hospital and Nursing Department's philosophy, objectives and policies. Nursing care is to be based on nursing practices which are based on scientific rationale, and use of the nursing process is expected. Excellent organizational and communication skills are to be demonstrated, with the expected effect to be effective interpersonal and interdepartmental communication. Professional self development is an expectation as is teaching of staff, students, patients and families. Primary nursing is the mode of organization used at the Victoria Hospital and is acknowledged in the job description. Nurses are to assume the primary nurse role, as assigned, and participate in discharge planning with the primary nurse and other team members.

St. Boniface Hospital also has a brief job description, developed in 1989. The use of the nursing process is expected and communication skills are acknowledged in the requirement for accurate reports of patient condition and treatment programs. Nurses in this institution are expected to supervise support staff, the only institution with this requirement. Nurses are expected to participate in education of patients, families, staff and students. Professional and personal development through educational programs is listed as an expectation. Leadership is expected as the nurse will assume the Head Nurse's responsibilities in that person's absence. St. Boniface is unique in its expectation for consultation with physicians and other nursing staff.

The Grace Hospital developed its latest job description in 1995. Staff or general duty nurses in this institution are referred to as direct care nurses, following the direction

provided by MARN in its latest version of Standards of Nursing Care (1994). Grace Hospital divides nursing responsibilities into six categories: communication, clinical practice, leadership, resource management, quality improvement and advancement of knowledge. The nursing process is the organizing framework of patient care, with an emphasis on interdisciplinary care planning and coordination, and teaching of patients and families. This job description is unique in that certain nursing components may fall into several of the categories. Professional development is mentioned in the leadership component as well as in advancement of knowledge, for example. Grace Hospital incorporates the Canadian Nurses' Association (CNA) Code of Ethics (1997) and the MARN Standards of Care (1996) into its expectations for nursing practice.

Health Sciences Centre also developed its job description in 1995. It is the lengthiest document, being seven pages in length. The responsibilities of the nurse in this institution are divided into five categories. These are nursing practice (based on the nursing process), teaching (of patients, families, staff and students), coordination and communication, research, and professional development. This job description promotes the active involvement of patient and families in decision-making and care choices. Active involvement of the patient and family is mentioned four times. The Health Sciences Centre utilized the problem-oriented charting method and this is acknowledged in the job expectations. The MARN Standards of Care is listed as a guiding document, but not the CNA Code of Ethics.

Misericordia Hospital developed its job description in 1993. Nurses in this institution are expected to practise according to the CNA Code of Ethics and the MARN Standards of Care. There is a required commitment to interdisciplinary consultive and

collaborative relationships with other members of the health care team, the only facility with this specific expectation. Nursing functions are five in number, and are directed toward the recipient of nursing care. These functions are the patient, professional responsibilities, the institution, the community and other. The nursing process is the organizing framework of the patient function, and involves teaching activities for patients, families, staff and students.. The patient is seen as the centre of all activities within the institution, and nursing staff are expected to act as patient advocates. Nursing research and professional development activities are incorporated under the professional function. The Misericordia is unique among all the hospitals in that, under the function of community, the nurse is expected to volunteer for health promotion/prevention activities and to act as a professional resource to community groups.

All the hospital job descriptions have elements in common. They utilize the nursing process as an organizing framework for nursing care. Teaching of patients, families, staff and students, professional and personal development as well as leadership qualities and involvement in and/or utilization of nursing research are similar in all institutions.

The differences between institutions provide a sense of the relative importance of certain nursing functions. Only St. Boniface and Misericordia Hospitals specifically identify a consultive and collaborative role with physicians and other interdisciplinary health care team members. Grace and Misericordia Hospitals specifically identified the CNA Code of Ethics and the MARN Standards of Care as guides to nursing care. Health Sciences Centre identified only the MARN Standards but not the CNA Code of Ethics. Health Sciences and Misericordia specifically identify the patient as the main focus of all

nursing and institutional activities. Health Sciences Centre was seen as actively involving the patient and family in active decision making and treatment choices. These vital elements may be mentioned in each institution's philosophy, and therefore, not mentioned in the job description. In summary, the differences between institutions appear to reflect each hospital's particular emphasis for its nursing staff. In a city the size of Winnipeg, a wide variety of diversities exists.

Another source that may give direction to the L&D nurse role are the Standards for Nursing Care of Women and Newborns (1991) published by the former NAACOG, AWHONN. These voluntary standards outline in great detail the specific tasks and functions required of a nurse in ambulatory and in-patient settings. Being voluntary, there is no guarantee that they reflect the reality of the nurse's role in L&D. It is useful, however, to use these standards and compare them to the Core Competencies identified by the College of Midwives of Ontario (1994) and identify similarities and differences between the two documents. This will elucidate the existence of role overlap or role differentiation, in the area of role expectations, between the L&D nurse and the midwife.

The AWHONN nursing standards outline the minimal requirements for nursing care of obstetric, gynaecologic and neonatal nursing. The following discussion is limited to intrapartum obstetric care as this is the area where the greatest overlap of responsibilities may occur. The nurse is "responsible for decisions and actions within the domain of nursing practice" (Standards for Nursing Care of Women and Newborns, 1991, p. 5) within the organizing framework of the nursing process. The nurse is expected to have knowledge of maternal and fetal health risks, normal process of labour, abnormalities of the labour process, electronic fetal monitoring patterns and interpretation

of same, and pain control methods (from psychoprophylaxis to regional blocks), to name just a few. She/he is also expected to have the ability to perform vaginal examinations, abdominal palpation, and initial assessment of the newborn. She/he is to have the ability to assess the mother's emotional status, cultural background, childbirth expectations and education, and goals related to her labour and delivery. The nurse is expected to provide emotional and physical comfort during labour. Provision of information about labour, pain control, and suggestions for involvement of the support person is expected, all the while promoting the woman's and her family's participation in the decisions that may need to be made.

Ontario is the only province which has a functioning midwifery program to date, although Alberta, Manitoba, and British Columbia will not be long in beginning their programs. The Core Competencies as identified by the College of Midwives of Ontario has been used to keep the information in a Canadian context. Ontario's midwifery program is representative, as it is based on work done in the United Kingdom and elsewhere.

The midwife in Ontario is expected to have knowledge of the normal process of labour, how to assess for maternal and fetal well-being, fetal heart patterns, risk factors, the abnormalities of labour, and comfort and support measures that can be used during birth. She/he is also expected to know the indications and procedure for performing an episiotomy, and the indications and procedures for repair of a laceration or episiotomy, again, to name but a few. The midwife is expected to demonstrate competency in performing (or conducting) a spontaneous delivery, vaginal examination, artificial rupture of membranes, repair of lacerations or episiotomies, delivering the placenta, identifying

and managing postpartum hemorrhage, and performing immediate newborn assessment and care. The midwife is to provide "supportive care" which is defined in the Model of Practice (1994) as education, counselling and advocacy. Labour support is defined as emotional and physical comfort measures and advice about coping with labour. The midwife is expected to provide these support measures to the woman and her family.

Although individuals within each group may hold varying beliefs (Davis-Floyd, 1992), the written documents regarding role expectations of nurses and midwives demonstrate the distinctions illustrated in Table 1.

Table 1: Similarities and Differences Between Formal Role Expectations of Labour and Delivery Nurses and Midwives

Similarities shared by the L & D nurse and Midwife	Additional Role Expectations of the L & D Nurse	Additional Role Expectations of the Midwife
~belief and skills in family-centred care, counselling/ communication skills, health education, health promotion and disease prevention, informed choice. ~practice based on ethical considerations. ~knowledge and skills for antepartum, intrapartum, postpartum and neonatal management related to anatomy and physiology, medications, fetal assessment techniques, diagnostic tests, risk factors, attachment behaviours, lactation, neonatal care, family planning, family dynamics.	~responsible for decisions and actions within the domain of nursing. ~duties are carried out in collaboration with other health team members. ~practices in hospitals.	~defined as an independent practitioner who may manage care through primary management, collaboration or referral. ~belief that pregnancy is a normal physiologic process. ~provides pre-conception and family planning/gynaecologic care. ~may have limited prescriptive authority. ~administers local and pudendal anaesthetics. ~performs vaginal deliveries. ~repairs episiotomies. ~practices in hospitals or clients' homes.

The similarities far outweigh the differences. The main differences identified in the written documents between the nurse and the midwife are the beliefs in pregnancy as a normal process, and the midwife functioning as an independent practitioner with some prescriptive authority. She/he is able to perform the skills necessary to facilitate a vaginal birth on her/his own responsibility, in either the home, birth centre or hospital setting. The nurse, in contrast, is responsible for decisions within

her nursing domain, and functions only in collaboration with other care providers, such as physicians. It must be concluded that, conceptually, role overlap appears to be the rule with very little role differentiation.

No studies were found that specifically studied the L&D nurses' perceptions of role expectations. A few studies were found that discuss the consumer's perspective. They provide some preliminary data regarding the perceptions of nurses' roles, but the purposes of the studies varied widely, as did the study methods.

The Consumer's Perspective of the L&D Nurse Role

Four studies (Bond, Keen-Payne & Lucy, 1995; Collins, 1986; Mackey & Lock, 1989; Mackey & Stepans, 1994) have examined the L&D nurse's role from the consumer's point of view. Such a view point is useful to consider, as patients exert influence over professionals' self-perceptions (Jecker & Self, 1991). The results of such studies will also give an interesting comparison with the nurses' perceptions of their roles.

Collins (1986) studies the role of the L&D nurse as perceived by two groups of patients who had different childbirth education (Lamaze and Red Cross Classes) and perceptions of L&D nurses to each of the two same groups of patients. The groups were small, 10 and 11 women each, and were convenience samples. The nurse group numbered 27, from three different hospitals. A Q-sort methodology was utilized after successful pilot testing. The specific hypotheses were: 1) the Red Cross prepared women will expect more physical support-nurse control from the nurse, 2) the Lamaze prepared women will expect more emotional support-mother control from the nurse and

3) the nurse will better meet the expectations of the Red Cross prepared women than the Lamaze-prepared women. T-tests were used for the analysis. None of the hypotheses were supported.

Clarity of terms in this study was very problematic. Although terms such as perception, role, and the type of preparation were well defined, a"physical support-nurse control scale", and "emotional support-mother control scale" were introduced with no explanation and no definition. "Expressive functioning" and "instrumental functioning" are introduced and discussed in reference to interaction with the two groups of patients. However, the meaning of these terms mean and their relationship to the patient or the study are unclear. Collins did contribute to the definition of the nurse role by developing, for the Q-sort, a series of fifty statements describing a nursing behaviour that could be seen to occur in L&D. These would be role expectations. Some examples of these behaviours are given in the text, and includes statements like "the nurse explains to the mother what the treatments and procedures will be like", and "the nurse cleans the mother after delivery" (p. 416). The question must also be raised, in view of the non-significant findings, if the Q-sort instrument was sensitive enough to find differences in expectations.

Mackey and Lock (1989) asked women to: 1) describe their expectations for nursing care in labour, and 2) define what "nursing support" meant to them during labour. A convenience sample was used and consisted of married low-risk women attending Lamaze classes (n=61). Only one woman did not participate, and none were lost to follow up. Forty-nine women were multigravida and 12 were primigravida. All women had normal uneventful deliveries. Most women were white (n=52), the mean age was

28.5 years, the mean education was 14.6 years and almost half were employed. The data were collected at 36-38 weeks gestation through semi-structured tape recorded interviews in the woman's home. The tapes were transcribed verbatim, and analysed using qualitative data analysis to develop themes. The specific approach to the qualitative analysis is not described.

Women in this study described a composite nurse who was calm, compassionate, concerned, considerate, friendly and understanding. This nurse accepted the woman's feelings, and said positive things. She was interested in the woman as a person. Women had seven categories of expectations. "Each category was defined by the nature of the nurse's participation in the following areas: 1) presence, 2) decision-making, 3) assistance, 4) physical assessment, 5) information, 6) comfort, and 7) support" (p. 507). The women differed in the amount and nature of involvement they expected from nurses. All women in the study groups had similar expectations for the categories of physical assessment, information giving and comfort. They did, however, have different expectations for presence (defined as the amount of time they wished a nurse to be with them), decision-making and assistance. Three categories of involvement were described: limited involvement (n=17), moderate involvement (n=22), and extensive involvement (n=22). Women in the limited involvement group expected nurses to leave them alone with their husbands during labour. They saw themselves as the primary decision makers, with nurses expected to respect their requests. Women in the moderate involvement groups saw nurses as collaborating with them to manage labour. Nursing support was defined as telling women that they were doing a good job, reassuring them of their progress, and giving them encouragement. Nurses were expected to be with the woman

and her husband on an intermittent basis. Women who expected extensive nurse involvement wanted nurses with them extensively, tended not to have strong opinions about how the labour should be managed, and wanted encouragement and reinforcement that the they were capable of managing their labour. Ten women in this group expected the nurses to be responsible for their comfort. Based on the results of the study, the authors described the expectations of nursing involvement as either technical, observational or as a participant. They also redefined support using the categories of presence, decision-making and assistance.

Mackey and Stepans' (1994) focus was the evaluation of the L&D nurse following delivery. The same population was used as that described in Mackey and Locke (1989). This study used tape recorded semi-structured interviews conducted during the postpartum hospital stay, except for two women who were interviewed in their homes on the third and fifth postpartum day. The interviews were conducted in a private room, at a convenient time for both the women and the staff. Again, a qualitative data analysis approach was utilized. Although the specific approach is not described, it appears to be a phenomenological design. The authors wished to discover the women's "experience" with their nurses during labour.

This study found that women evaluated their nurses primarily favourably (n=55). Twenty-nine of the 55 women reported only positive experiences. Twenty-six of the 55 women had one disappointing encounter. Ten per cent (n=6) of the sample gave negative evaluations. Of these six women, only one woman had only negative encounters. The recurring themes of the evaluations were participation, acceptance, information giving, encouragement, presence, and competence. These categories were

ranked in terms of how often women mentioned these themes in describing their L&D nurse. Participation was mentioned by 80 percent of the women, acceptance by 78 percent, information giving by 75 percent, encouragement by 65 percent, presence by 53 percent, and competence by 7 percent. Women expressed disappointment in three categories: acceptance, information giving, and presence. Unfavourable evaluations occurred in three areas: presence, information giving, and the manner in which the nurse interacted with the woman and her husband. It is interesting in that "manner" was not identified as a theme in the study, but is continually mentioned throughout the text as a factor, and was mentioned as one of the themes in the unfavourable evaluation.

The authors concluded that nurses' interpersonal skills are as important as their technical skills. "Although technical competence is important, the nurse's manner, provision of supportive care, and acceptance of each woman are also important" (p. 419). Information needs were extensive, even though most of the women were multigravida.

Bond, Keen-Payne and Lucy (1995) conducted a study, as part of a larger multiphase study, to describe the "ideal nurse" during L&D for the relinquishing mother (the woman voluntarily giving her baby up for adoption). The sample used was a non-probability self-selected sample of 56 women living in a residential care centre that provided inpatient obstetrical and newborn services for women and their infants. All women in the sample were single, ranging in age from 15-34 years. Most women were between 18-20 years of age. Thirty-nine women had some high school education or had completed high school. The remainder had taken some college courses or had a college degree. It was the first pregnancy for 41 women, and for 11, the second pregnancy. All of these women knew their nurses well as they [the women] lived in the maternity home

for most of the second and third trimester and had daily interaction with the nurses. They did not have family members or significant others available to be with them during labour. The study was conducted through the use of semi-structured focused interviews by two trained interviewers, 1-2 weeks postpartum. Content analysis was used to examine the data.

The sample of women described their ideal nurse as knowledgeable and competent, accepting and caring, and who would be a continuous supportive presence. The women identified what, to them, would be important caretaking activities: assistance with pain relief, coaching, informing, attention to bodily comfort, and using touch to establish the nurse's presence. The authors acknowledge that it is impossible to generalize their findings. They state that the study "provides confirmation of valued support behaviours, in particular, the nursing presence" (p. 159).

There are some methodological problems with this study. Most of these women had no other exposure to other nursing care during labour, and knew their nurses well. As it was a residential setting, it is assumed the same nurses would still be caring for these women in the postpartum period when the interviews were done. The question of bias must be raised. The report does not indicate how many women felt that comfort, knowledge, and competence were important. The authors report all categories as being equal, which may not be the case.

The above three studies, despite different samples and methodological problems, have similar results. Women determined that nursing care during labour must include acceptance of the woman and a supportive nursing presence. Mackey and Locke (1989) provide a useful definition of support for labouring women. Support includes the

elements of: the amount of time each nurse spends with the mother, the amount of decision making done by the nurse or the mother, and the amount of assistance the mother wishes. Two of these elements (the amount of time spent with the mother and the amount of assistance the mother requires) may be fairly easily quantified and measured to gain a better indication about what actually happens during woman-nurse interaction during labour.

Beaton and Gupton (1990) conducted a study intended to develop an instrument to measure childbirth expectations. Eleven white middle class women in their third trimester of pregnancy were recruited from a childbirth education class. Written consent was obtained, and interviews were conducted in the woman's home. Women ranged from 24-35 years of age. The women in the sample were well educated with all having completed high school, and five having university degrees. Nine women were expecting their first baby, while two had other children. Transcripts of the taped interviews were analysed for "thematic content relative to the major interview topics" (p. 134).

The major themes were related to childbirth concerns, childbirth emotions, pain and coping, the role of the support person, the role of health professionals, intervention, and the childbirth environment. Of interest to this study was the perception of the role of health care professionals, specifically nurses. "Women viewed the nurse's role in labour as primarily assisting the physician and monitoring the progress of labour. Nurses were expected to take vital signs, perform examinations, check fetal heart rate and change the sheets. Only four women expected the nurse to offer encouragement and emotional support. Most women did not know what the nurse would be doing during delivery" (p. 137). This study is important as it was conducted in Winnipeg, with participants drawn

from childbirth education classes offered at a Winnipeg hospital. It offers a snapshot of the local impression of the nursing role expectations from the consumer's viewpoint.

Nurses' Supportive Care During Labour

A Canadian study by Beaton (1990) studied the interaction between women in labour and nurses providing their care. The research question was to determine whose definition of the labour experience predominates, the nurse's or the woman's.

The sample was a convenience sample of 33 women having their first baby, admitted in early labour. Inclusion and exclusion criteria were identified. Thirty registered nurses who worked on the L&D unit agreed to be the nurse participants. Data was collected using a combined time and event sampling strategy. All observed nurse-patient interactions were recorded in short-hand, and later transcribed. Nurse-patient interaction was analysed using Stiles's Taxonomy of Verbal Response Modes.

The results demonstrated, rather conclusively, that "Nurses structured the childbirth experience according to their own definition of the situation and so controlled the social context of childbirth" (p. 406). Beaton found that nurses ignored the patients' attempts to express what the experience was like. Nurses presumed what the patients were experiencing, and "could carry on with what appeared to be their task of getting the baby born as quickly and efficiently as possible" (p. 405). Mutual participation in decision making between the woman and nurse seldom occurred, and appeared very similar to the classic physician-patient relationship. The value of this study is that it, too, was done in a Winnipeg hospital, and may reflect another local reality.

Another Canadian study by McNiven, Hodnett and O'Brien-Pallas (1992)

determined the proportion of time the average L&D nurse spent in supportive care activities. Support, in this study, was defined as the "verbal and nonverbal behaviours that convey caring and understanding to enhance an individual's ability to cope" (p. 3). Support to labouring patients was conceptualized as having four dimensions: emotional, informational, tangible and advocacy. An exhaustive and mutually exclusive list of supportive activities representing each of the four dimensions was made. A work sampling technique was used to collect the data. Work sampling is a "quantitative measure, identifying the frequency with which the work activity under observation occurs and calculated for an average staff member" (p. 4). The sample consisted of randomly scheduled observation of nurses working the day shift in a Toronto teaching hospital. Eighteen nurses were observed with a total of 616 observations being made. The patient population in this hospital was white, well educated and socioeconomically advantaged. Sixty percent of the patient population were considered low risk, 80 percent had epidural anaesthesia, with a Caesarean section rate of 23.5 percent.

The results showed that the percentage of time spent in supportive care activities, estimated for the average staff nurse, was 9.9 percent. The greatest number of supportive activities were in the domains of instruction and information, with a virtual absence of observations in the domains of physical comfort measures and advocacy. The authors conclude that supportive activities have been devalued, partially because they have not been formally acknowledged and encouraged. In addition, "...qualities such as decisiveness, lack of emotion, and intelligence tend to be highly valued and are associated with medical intervention and related tasks" (p. 6).

The results of this study and Beaton's (1990) reinforce the idea that the current

medical system emphasizes the fragmentation and separation of care as discussed by Davis-Floyd (1992) and Sandelowski (1988). Nurses, in these studies, are reinforcing the medical model despite the emphasis in formal nursing programs and the literature on care and support. It would be interesting to replicate these studies in facilities that had lower epidural and Caesarean section rates to determine if this behaviour persists in a less "medicalized" environment.

Role Conflict Between the L&D Nurse and Midwife

Only one study that examined role conflict was found. Hazle (1985) examined the perceptions of the certified nurse midwife's (CNM) role and role conflict with the L&D nurse by means of a questionnaire developed for the study. A sample of 85 CNMs and 60 nurses was used. The CNMs were a regionally stratified sample from across the United States. The nurses were a convenience sample, stratified from similar areas as the CNMs. The two samples varied, in that the nurses were generally ten years younger, and worked in state or federal hospitals. CNMs usually worked in private hospitals. The results indicated that there was role conflict between the two health care providers. Both CNMs and nurses defined their roles as primary care provider, support person and advocate. Nurses tended to define the CNM role into two, a management role and an obstetric nursing role. Part of the questionnaire asked for a description of a situation in which there had been conflict between a nurse and a CNM. Content analysis was performed to elicit themes. The largest category of responses (17) concerned conflict over tasks. There appeared to be uncertainty regarding "who does what, when and where" (p. 171). The author concluded that inter-role conflict between CNMs and nurses

was evident. Confusion about the CNM role was reported more by nurses. Some solutions were offered, such as improved communication methods, and explicit policy and procedure manuals, were offered .

The major value in this study is not so much in the conclusions, but in the study tool. The tool itself is very poorly described in the text, but extensive use of tables makes the tool more explicable by inference. A list of attitudes are described with a Lickert scale rating. The attitude scale describes identical nurse and CNM behaviours for care of the intrapartum woman. The attitude scale measured nurses' perceptions of CNM behaviours and CNMs' perceptions of nurse behaviours. Hazle discovered both role conflict and role overlap, though no estimations are given as to how significant a problem this is. Respondents were invited to describe a conflict situation they had experienced with a CNM (if respondent was a nurse), or a nurse (if the respondent was a CNM). There were 50 responses from a sample of 145 respondents. Therefore, a full two-thirds of the sample apparently did not perceive conflict as a problem. It is crucial to remember, in this American study, that midwives and nurses have worked together for years. Conflict may not be perceived as much of a problem. However, in Canada, midwifery is just beginning to be legally sanctioned. Conflict might thus be expected to be much greater.

The literature review has not been helpful in describing role expectations or role performance of the L&D nurse. Only generic role expectations and formal role expectations were found. Winnipeg hospitals do not have specific job descriptions for L&D nurses. Comparisons of the formal role expectations of the L&D nurse and the midwife indicate significant overlap. Consumer expectations, for the most part,

emphasize the importance of psychosocial interaction, and also identify that women differ in the amount of interaction and support they expect from their nurses. Quantitative studies indicate that nurses are much more involved in the technical aspects of nursing, and don't listen to their patients. Moreover, in the U.S. there does appear to be role conflict between CNMs and nurses. This study will attempt to elicit the perceptions of L&D nurses as to their role expectations, role performance, and philosophy of birth.

Chapter 4 The Research Design

A research design is a detailed blueprint which outlines and explains how the research question is to be answered (Schantz & Lundeman, 1982). It follows the identification of the research question, the literature review and the problem statement. This work needs to be done first, for from the research question flows the research design.

The first question of research design revolves around whether the research question requires a qualitative or quantitative approach. The research question meets the assumptions of exploratory studies in that the topic, the description of the role expectations and role performance of the L&D nurse have not been studied (Brink and Wood, 1989, p. 145). Therefore a qualitative approach is most appropriate. Artinian (1988) calls this the descriptive mode, and states it must precede all other levels of research. The descriptive mode is "...used to present a detailed description of what is happening in some setting or with a particular group of subjects, so that the point of view of the subjects can be understood" (p. 138).

Ethnography is the qualitative approach that has been chosen. It is based upon the study of anthropology and is used to "address those questions how cultural knowledge, norms and values, and the like influence our own and our client's behaviours" (LiBiondo-Wood and Haber, 1990, p. 188). This inductive approach is useful in the description of the role of the L&D nurse as it acknowledges the impact of culture, attitudes and values. It relies upon interview and participant observation as data collection tools with "key informants". Key informants are members of a culture selected for their knowledge of a culture and their ability to share their knowledge (LiBiondo-Wood and Haber, 1990; Morse, 1989). As organizational culture and climate are integrated into the conceptual

framework, ethnography seems well adapted to the study questions.

Although participant observation is a suggested element of an ethnographic approach (Leininger, 1985; Morse, 1994; Munhall and Oiler, 1986), it will not be used in this particular study, However, field notes will be utilized.

Sample Recruitment

Nurses need to have been employed for at least three years as a full-time nurse so as to have a comprehensive understanding of the L&D nurse's role. There may be a variation of the role for the nurse, depending on the place of employment. Community hospitals tend to care for low risk women, whereas tertiary care institutions will care for a greater number of women who have or develop complications during pregnancy. The focus on low risk/low technology birth versus high risk/high technology birth may influence how the nurse perceives her role in the birth process. It is important to capture both points of view. The exclusion of nurses who are also midwives will eliminate the effect of a view of birth, or alternative service delivery (as in England) upon the perception of the reality that now exists in Manitoba. The purpose of the study is not to examine "what should be", but rather "what is".

The nurses in this study have been employed as full time nurses for at least three years in a L&D unit in Winnipeg. The sample included nurses working in both community and tertiary hospital settings. The basic nursing education was either hospital or university based, but the sample did not include any nurses with a midwifery education(Appendix D, Guidelines for Selection of Nurses).

The sample was accessed from the Health Sciences Centre, St. Boniface Hospital,

Misericordia Hospital and Victoria Hospital, four of the five institutions in Winnipeg offering obstetrical services. The Grace Hospital was not accessed due to ethical considerations.

Permission to access the staff in each institution was sought. Nurse Managers/Head Nurses from each participating institution was given an Invitation to Participate (Appendix C) which outlined the researcher's expectations of them. Each Nurse Manager /Head Nurse was asked to identify three to five L&D nurses, from their staff, who demonstrate superior knowledge and skills in caring for labouring women. Guidelines and inclusion criteria were provided (Appendix D). The Nurse Manager/Head Nurse gave each identified nurse an Invitation to Participate (Appendix E). The nurse expressed her/his interest in participating in the study by telephoning the researcher.

After a waiting period of about eight weeks, and after verifying that Nurse Managers/Head Nurses had provided the selected nurses with Invitations to Participate, only two nurses had been in contact with the researcher. Ethical approval was sought from the Faculty of Nursing as well as from each institution to change the recruitment procedure. Nurse Managers/Head Nurses provided the researcher with the names and telephone numbers of the selected nurses. The researcher then telephoned each nurse and received verbal consent to participate in the study. A date and time for the interview was arranged. Written consent was obtained at the time of interview (Appendix F).

Nineteen names were received. Of these 19 people, two refused to participate for unknown reasons; one nurse moved out of the province before data could be collected. This left a final sample size of 16 nurses, seven from community hospitals and nine from tertiary hospitals.

The Setting

The method of data collection was through taped interview. A quiet environment, free of distractions, and away from the work setting facilitated free expression of nurses' feelings and thoughts. At least one to one-and-one half hours of the subject's time was required and asked for, in a setting of their choice. This left the feeling of control of the interview in the hands of the participant, which increased her/his comfort level.

Procedure

At the time of the interview, the participants were encouraged to describe the perceptions of the role expectations and role performance of a L&D nurse. The interview was audio-taped. Data collection was expedited through use of an Interview Guide (Appendix I). Demographic data collected immediately before the interview (Appendix G). Field notes were taken.

Data about the organizational and unit climate and culture were collected from each institution. Nurse Managers/Head Nurses completed the Institution Data Collection Form (Appendix H) and mailed the information to the researcher in a supplied stamped self-addressed envelope.

Data Analysis

The taped data were transcribed onto a computer file so that both a hard copy and computer record were available. The computer information was backed up on several

disks to guarantee that the data could not be lost.

The interview data were analysed utilizing thematic content analysis as described by Burnard (1991). This is a 14 stage process that aims to "produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system" (Burnard, 1991, p. 461-462).

Data analysis of an ethnographic study is a time consuming process that requires immersion in the data to determine recurrent themes and patterns. The data are then reviewed repeatedly to determine how many times the identified themes are mentioned by the informants, or if the themes are consistent within each interview, and between the interviewees. It is probable that themes will change and evolve with review, with additional themes being identified, and others collapsing into new themes.

This research took place within "the here and now". In Manitoba, "the here and now" included the influence and uncertainty of health care reform. Nurses in each settings are feeling threatened, as all face job layoffs or job relocation as the reforms are announced and implemented. In fact, during the actual data collection process, the Misericordia Birthing Unit received its formal announcement of closure. How this affected the data is unknown at the present, but the current environment and atmosphere must be acknowledged.

Ethical Considerations

Ethical considerations have been considered throughout the research design. Permission to access employees was sought from the institutions; informed consent was

sought from each participant. Privacy, anonymity, and confidentiality of the informants was protected at all times. All data will be secured in a locked filing cabinet until the completion of the project. Once the project is complete the data will be kept for 10 years, then destroyed. Information about each participant will be sought only from that person. Information gathered during the interview will not be relayed back to the institution. A code was utilized so that individual institutions will not be associated with the data. No names or codes were associated with the interview data. Physical stress was not involved, nor was there any threat to the physical safety of the participants. The participants were legally and practically able to consent to participate. Deception was not involved. Subjects were free to withdraw from the study at any time with no ill will or risk. Participants were offered an opportunity to receive a copy of the results of the study once it is completed. No individual was identified in the data. Only group results are reported. Only the thesis committee had access to individual data. This information was included in the Invitation to Participate (Appendix C) and the formal Consent to Participate (Appendix D).

The Grace Hospital and its nursing staff were eliminated from the research design. The researcher holds the position of Head Nurse of that Birthing Unit, and thus is in a position of authority. It was unethical to include these nurses in the study.

Study Limitations

Qualitative studies cannot be measured by the measures that are used for quantitative studies. Rather, qualitative studies are measured by credibility, fittingness and auditability (Tatano Beck, 1993). Credibility measures "...how vivid and faithful the description of the phenomenon is" (p. 265). The use of extensive field notes, and validation of the findings with some of the informants, as well as looking for negative instances assisted in establishing credibility. Fittingness refers to whether the hypotheses fit into another context (Tatano Beck, 1993). The method of sample selection will begin to establish whether the participants are typical of other nurses in their experience and expertise. Auditability is the "...ability of another investigator to follow the decision or audit trail" (p. 265). Auditability was ascertained by the use of a tape recorder, the demographic data of the participants, clear description of the study procedure, and the review of the data analysis with the thesis advisors.

Chapter 5 Results

Sample

The sample size was 16 nurses (N=16). Table 2.1, 2.2 and 2.3 illustrate the sample demographics.

2.1 Sample Demographics: Age and Nursing Experience

	Range	Mean
Age (years)	28-55	38.75
Years of Nursing Experience	7.5-34	16.78
Years of L&D Experience	3.5-25	12.21

Table 2.2 Sample Demographics: Education

	Diploma	Degree
Basic Education	15 (93%)	1 (7%)
Highest Education	14 (87.5%)	2 (12.5%)

Table 2.3 Sample Demographics: Type of Institution for First and Present Nursing Position

Type of Institution	First Position	Present Position
Rural	2 (12.5%)	0
Community	6 (37.5%)	7 (37%)
Tertiary	8 (50%)	9 (63%)

The participants ranged in age from 28 to 55 years, with a mean of 38.75 years. Years of nursing experience ranged from 7.5 to 34 years, with a mean of 16.78 years. This group of nurses had many years of experience in L&D, with a range of 3.5 to 25 years, and a mean of 12.21 years. Most nurses had a diploma in nursing (RN) as their basic education (93% or n=15), with one having a Batchelor of Nursing (BN) as the basic education program. One nurse of the 15 had earned a BN subsequent to her diploma preparation. Two (12.5%) nurses had their first nursing position in a rural hospital. Six (37.5%) nurses began in community hospitals, with eight (50%) beginning their careers in tertiary settings. Seven nurses (37%) presently worked in community hospitals, with nine (63%) working in tertiary settings. Three nurses (18.75%) have only worked in L&D, with the remaining 13 (81.25%) having worked in other clinical areas during their nursing careers. However, of this sample, 12 nurses (75%) have only worked in one L&D unit, the one in which they are presently employed. Four nurses (25%) have worked in L&D settings elsewhere. Six nurses (37.5%) have worked in other institutions, whereas 10 (62.5%) have only worked for their present employers. The large number that have only worked for one employer may reflect on the variables of organizational culture and climate. These nurses have not experienced any other organizational functioning.

Table 2.4 Sample Demographics: Work History

Item	Yes	No
Only worked L&D	3 (18.75%)	13 (81.25%)
Only worked in 1 L&D unit	12 (75%)	4 (25%)
Only worked for present employer	6 (37.5%)	10 (62.5%)

Perceptions of Role Expectations

Nurses were asked to describe the best L&D nurse they had ever met. This was one method of eliciting role expectations. Most were able to graphically describe a nurse who they felt was an ideal L&D nurse. Often, the ideal nurse was not described in terms of what skills she had or how fast she could perform them, but rather in her approach and manner with women and their families.

> To me, that is what being a labour and delivery nurse is, aside from having all the other skills...the most important thing is being there for the patient to coach, and encourage, and support, and that is how I think it should be...(#3)
>
> All the things I said about an ideal nurse are the things I do...I really do make a point of trying to figure what the patient's needs are. Not even so much physically, but psychologically; what is going to work between us. (#10)

Nurses were very clear in describing attitudes and behaviours of the ideal nurse. There did not seem to be significant differences between community and tertiary care settings. Role expectations' themes, emerging from the data, developed into two streams: personal attitudes and behaviours, and professional attitudes and behaviours

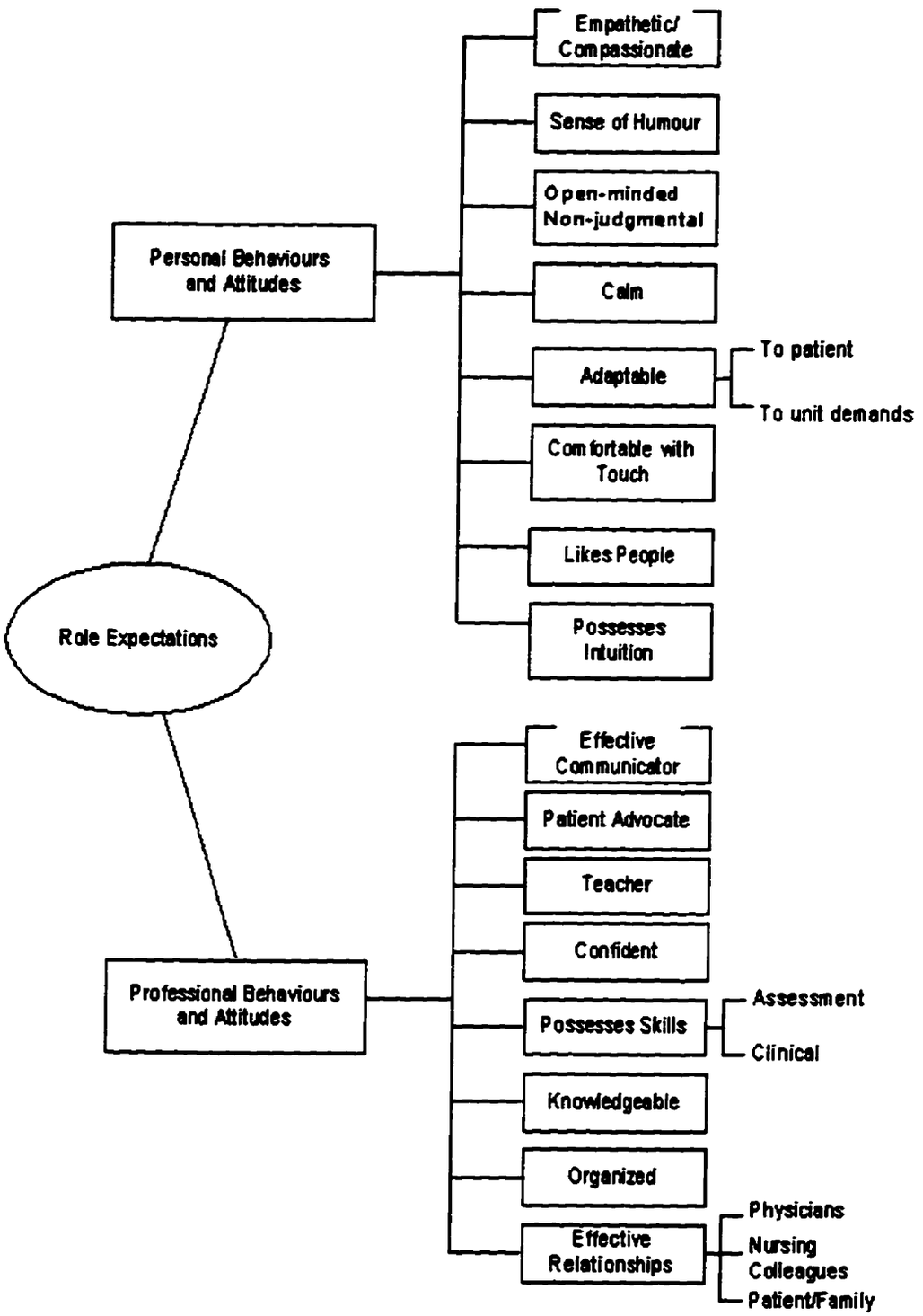


Figure 3: DIMENSIONS OF ROLE EXPECTATIONS

(see Figure 3).

Personal Attitudes and Behaviours

Personal attitudes and behaviours included: empathy/compassion, sense of humour, open minded and non-judgemental, calmness, adaptability and flexibility to the needs of patients, and to the work demands of the unit, comfort with touch, likes people, and intuitiveness.

Ideal L&D nurses need to be empathetic, and understanding of the woman in labour. It was thought to be important not to take the patient's behaviour personally. Sometimes, women became physically and verbally abusive when in labour, but, as one nurse reported, "... women are not themselves when they are in labour. So you would have to be very accepting and supportive of however she is getting through this" (#6). Nurses also reported that women can tell when her nurse is empathetic. In some cases, empathy was synonymous with being a "hands on" nurse.

> [Empathy] is really important. That is probably the ability to bond with somebody and the empathy that you like patients or that you feel for them and they know that. They can tell. They can sense when you are a hands on nurse, it doesn't matter that what you do [as a nurse] is normal. It [labour] is no big deal. This happens to all of us [women who give birth], versus somebody that is sort of a little hands off. (#16)

Compassion was a quality valued by this group of nurses, and was often mentioned in the same sentence as empathy.

> Well, I think compassion and empathy are the things that you most have to have...a lot of patients look at you funny if you haven't had children...they think, how can you possibly do this? How can you guide me through this when you have never done it? That is where I think [that nurses help by being] able to put yourself in the patient's position, and to be able to help them just by...recognizing what they are going through... (#14)

Caring was a non-verbal skill mentioned by many nurses, but was never defined. It was used as a verb and as a noun. It was described as a type of manner or approach, and combined with the word "compassionate". It is difficult to know, in the context of these interviews, whether caring is a summation of several qualities, or a separate entity unto itself.

A sense of humour was mentioned as a vital quality by several nurses. It was seen as important because it relieved tension on the unit and with patients.

> I guess you can get away with a lot more humour on a labour floor that you could anywhere else and the humour really does relieve a lot of tension. I guess my ideal nurse has an incredible sense of humour. She doesn't hold it back from anybody...Humour breaks down a lot of walls. (#8)

However, it was recognized that there are a place and time for humour. It also depended on whether humour was appropriate for the situation or the nurse's peers with whom she was working.

Nurses identified that it was important to be open minded and non-judgmental. Being culturally sensitive was mentioned specifically by one nurse. The ideal nurse should not bring her/his ideals and morals to the unit.

> I think that the perfect L&D nurse, as with any other nurse, has to be completely without prejudice and not impose your own values and beliefs on the people you are caring for. I don't care if she is upper or middle class woman who is a doctor, lawyer, or what have you, or whether she is a core area glue sniffer. She deserves absolutely the same care and the same consideration and the best outcome possible. (#14)

One nurse recognized how difficult this can be:

> They [patients] often want to know a lot about you, too. How did you do this, have you had a child before? So you have to be able to share a little bit of yourself without letting your ideas, your judgements, that sort of thing. My labour was this, so therefore, your labour should be this, interferes too much in your work. It is kind of hard right off the top of your head to pull things out [of the conversation]. (#9)

The ability to remain calm in stressful or crisis, or even very busy situations was seen to be an important quality in the ideal nurse. Calmness is demonstrated by non-verbal behaviours and soothing voice tones. "...if they [patients] came in smiling and a little nervous and stuff, she had a very calming effect on people and she talked in a very soothing voice" (#7). Calmness was "catching". If the nurse was calm, the patient could be helped to be calm as well. The opposite of calmness was said to be panic. If a nurse panicked, the woman "caught" the panic.

> I think one of the major things is they [nurses] have to have a very calm personality. When people come in, they are usually uptight, they are scared. They are working at a really high anxiety level. You need to have a nurse who is

> calm and who can just talk them down, and yes, this is really exciting, and it is, but we are going to get through it, and it is going to be just fine. The more uptight you get, the more uptight your patient gets, and then you both lost it, and that helps with the pain too. If you have a really calm nurse, then it is catching... (#8)

A nurse who has difficulty being calm will "infect" other nurses as well. "...Although some of the nurses are very good with the patients, and they are technically very good, they are right on the edge. It takes nothing to really get panicky and to get excitable and it affects the rest of us on the ward" (#10).

The ideal nurse needs to be adaptable and flexible to the needs of the woman and her family. Each woman is seen to be an individual, and requires an approach that is unique to her.

> Some people go in with the same approach regardless of who the patient is, ... that doesn't work with late thirties lawyers, and a 17 year old kid that is scared to death. It doesn't work the same, and if you can't adapt to that, it shows. (#10)

The ideal nurse also needs to be adaptable and flexible to the work demands of the unit. This may mean switching patient assignments part way through a shift, for example. "Where I work...I find the charge nurses are very adept at seeing what is going on, and the nurses...are more than willing to provide that...have another nurse look after that other patient" (#13). "...this patient we had was totally out of control, verbally abusive, almost physically abusive...they rotated [the nurses] until this baby was finally out. That is team work..." (#13).

Another personal attribute of the ideal L&D nurse was comfort with touch. The ideal nurse should use touch frequently and should feel comfortable with using touch.

This information was rarely spontaneously offered by the participating nurses. When questioned directly about the importance of touch, all agreed that this was an important aspect. "...I think we have to be tactile...if it is appropriate to that patient" (#14).

Nurses felt it was very important to be good with people and to like working with different kinds of people, particularly women. One nurse said,

> You have to like all sorts of people. You have to accept people...that everyone is going to be a little bit different. So they are different and maybe they are a little strange sometimes, but that is okay. That is what makes people interesting and you don't have to live with them for the rest of your life. (#16)

Another nurse stated, "I think you're involved in such an intimate time in a woman's life...you have to believe in women and [in] the strength of women" (#9).

Part of demonstrating "like" for people is being friendly and approachable. A smile was often mentioned as required behaviour.

> I want someone to come through the door, who, I have this mental image of what a L&D nurse looks like, and she has a smile on her face, and she is friendly right off the bat. There is none of this sort of hold back. You just give it all to them. (#2)

The ideal nurse had a strong sense of intuition. Nurses indicated that it seemed either nurses had it or they didn't; years of experience did not affect intuition. "I have a very strong belief that labour and delivery nurses are not made, they are born" (#2). Intuition was referred to as a "sixth sense", and involved more that just anticipating what was going to happen next, or how the woman's labour was progressing. It appears to incorporate clinical skills, psychosocial skills, touch, and knowledge. "She just seemed

to have the ability to initiate a rapport and be friendly right off the bat and was able to comfort without seeming to come on too strong. She seemed to know when to say the right thing, when to touch in the right place" (#3).

Professional Attitudes and Behaviours

Nurses identified eight professional attitudes and behaviours that the ideal nurse should possess and demonstrate: being an effective communicator, being a patient advocate, being a teacher, displaying confidence, skills (clinical skills and assessment skills), knowledgeable, possessing organizational skills, and developing effective relationships with patients and families, nursing colleagues, and physicians. See Figure 3 for the diagrammatic relationships.

The most frequently mentioned skill that the ideal nurse should possess was being an effective communicator. Nurses talked about this quality in more detail than all others identified so far. Being an effective communicator was of benefit not only patient and family care, but also facilitated nurse-nurse and nurse-physician relationships. With regard to patient/family communication, it was thought to be important to establish rapport with the patient and family immediately. Rapport was essential to the woman acquiring a sense of trust in her nurse. Instant rapport makes it easier for the nurse to identify what the woman's expectations are, and thereby try and modify the birthing experience, so that some of the woman's expectations are met. A nurse states,

> ...I want them to be comfortable with me so when I meet them, and I am talking with them, I decide how I am going to be with them, because I am going to be their support person. They are going to be asking me questions. I want them to

> be able to feel that I am their friend. I want you to feel really comfortable with me...I really try to put myself in your place...I don't want them to feel that I am better than they are so I try to ...really make them feel like we are compatible....You have to make them feel that you are there and you bond quickly...that is really important to do. They really depend on you. You are their anchor when you really had to be there with them, right with them, sitting beside them, sitting on the bed beside them. (#16)

Nurses need to communicate with their colleagues in a clear and objective manner. Communication skills with physicians, particularly, were identified as being important. "Residents, interns, med students, of the obstetrical variety, of the anaesthetic profession, pediatricians, the peds residents, all of these people have to be informed and spoken to. Your communication has to be effective. It has to be objective. Therefore, the intonation in which you deliver messages...is very important and...I cannot stress objectivity enough" (#1).

Most nurses from all settings described the role of patient advocate as an important one. "You are their advocate, and where I work, we are really their advocates because we sort of control and do their labour and delivery. The doctors aren't there, we all know that, and they don't stick around in the hospital" (#2). Most nurses saw the role as including mediation. When there was a discrepancy between physician treatment plans and patient expectations, the ideal nurse would advocate for the patient; she/he would express the patient's desires to the physician, and would attempt to negotiate a compromise.

If the physician is there in the room, and the patient has voiced her opinion to the

> physician, and the physician is staying firm [with his/her opinion]...I think I would talk to the physician outside and say, look, could we not give her a few more hours. Compromise a little this way. (#11)

A nurse from a tertiary setting expressed a radical view: nurses need to protect patients from physicians. "[In] a teaching facility, you are so often having to really guard the patient from over-doctoring, from having too many people there and too many things going on...I think that ideally, we shouldn't be afraid to approach the doctors" (#10).

The teaching component of the nurse patient relationship was considered important, with every nurse commenting on this aspect. Teaching was constant, ongoing, and incorporated into the care. It should be geared to the individual patient, dependent on patient knowledge levels, age, educational level attained, and patient receptivity. Nurses acknowledged that if the patient was in too much pain, or scared to death, she probably would not be hearing much of what the nurse had to say. One nurse referred to it as "as you need it education" (#14). Another stated,

> You only have such a short period of time,... if this lady is in labour and she comes with no ideas or knowledge of the labour process, you are giving her a crash course. You are also doing it to multi different cultures and socioeconomic groups, and that sort of thing, so you have to be able to gear that teaching to that individual patient and try to decide what needs to be done, and what is the most important, and doing it in a comforting way, being able to decide she is not ready to receive this information, we have to do it another time; or else it has to be very simple because I may just be giving her a few, almost, commands right now, as I tell you this is how we are going to push, or this is how we should do this. (#9)

Many nurses felt that it was very important to demonstrate confidence in oneself and in one's skills. In fact, one nurse thought that one should "exude" confidence. Women "knew" when the nurse was confident, and it helped the woman and her family feel safe. The best nurse that one participant had ever known approached patients "...very confidently. She knew what was going on, and they [the patients] knew right away that she was very sure of herself. She knew how to do her job, and she wasn't going to let anything happen that shouldn't happen" (#8).

Two nursing skills were specifically identified as being important. Clinical skills are needed in order to do the job well. Such skills include vaginal examinations, fetal monitoring, venipuncture, and so on. Nurses did not specifically identify what these skills were. Nurses talked much more about the importance of assessment skills. One nurse emphasized the importance of assessment saying, "Your assessment is everything because the pieces fall... into place after that, your evaluation of what you have done, all of that depends on an accurate assessment" (#1). Nurses mentioned the importance of psychosocial assessment more than any other kind of assessment. It was necessary to find out what the patient wanted out of the experience, so that nursing care would be directed toward this end. A nurse stated,

> ...if you can do that, know where they are coming from, I think it gives you a basis. Anybody you admit, it is nice to know, as long as they can express it at that time, what they expect out of this experience, what they would like to see happen... I think a good labour nurse will find those things out before things really get going and try [and] direct the labour that way, if you can, within the parameters. (#6)

The ability to assess the psychosocial domain was considered by many nurses to be an intuitive ability and not one that every nurse has. As a nurse stated,

> Ninety per cent of the time, you can walk into the room and you get a feeling for what is going on in the room. You can tell if the husband wants to be there or not...you can tell if the patient has a good knowledge base of what is coming up and what is going to be happening, or if you are going to be sitting and explaining every step of the way...If you can get that from them, and you usually do quickly, then you can get the patient comfortable quickly and you can get some kind of rapport with them. There are times when you get relief for break and you regret seeing who is going into the room because you know they are just not even going to try, or they are not going to get that approach with them [the patient] at all... They don't catch that what they [the nurse] are doing with the patient isn't working. (#10)

Nurses felt it was important to be knowledgeable about the normal process of labour, and the necessary technology in order to do their job. Nurses in community settings specifically emphasized the need for knowledge of the "normal" labour, whereas only one nurse from tertiary settings specifically mentioned that knowledge requirements should include critical care components. Tertiary care nurses more often mentioned that knowledge of technology was required. However, nurses in all settings more often emphasized that it was very important to realize one's own limitations and to know when to ask for help. Not to know one's own limitations was recognized as dangerous. One nurse stated,

> ...[you need] to know when you have to ask for help. We do get that; they just

> don't know when they are in over their heads. Interviewer: Is that a lack of knowledge, perhaps? Participant: Not always. I guess it is. It is a lack of knowing what is too much. I don't know if it is that they don't realize that they are in too deep, or they are just not with it enough to recognize it. I don't know if it is pride. They don't want to ask for help. They are afraid to ask for help. (#10)

The ideal nurse was thought to need good organization skills. To be organized, the nurse needs knowedge and good clinical skills, be able to anticipate events, set priorities and make quick decisions. A nurse stated that good clinical skills, and good knowedge were needed as well as "...a quick mind to use them in a hurry. Because it all happens so fast. Everything that you will sit and wait for, 10 hours is over in five minutes or less. You do have to really think on your feet and have the skills to back everything up" (#14).

The role of the nurse requires that she/he have complementary roles with three other groups: patients and families, nursing colleagues and physicians. Therefore, the ideal nurse will have effective professional relationships with these groups. The groups of nurses interviewed identified the qualities these relationships should have.

The ideal relationship with nursing colleagues should be characterized by mutual respect, team work, sharing of the workload, and most importantly, the ability and willingness to consult with each other. One nurse summarized the collegial relationship this way:

> ...she would keep her charge nurse informed of what is going on with her patients. She would have an ability to interact with a team of nurses, work well together, share the work load..and also act as a resource person. If she was a more senior person, she would be able to act as a resource person to more junior people and

understand that she was a junior person at one time, too. (#4)

The ideal relationship with nurses and physicians was thought to be more equal now than in the past. Many nurses felt the relationship should be like a partnership, with each doing different, but equally important activities. Communication skills are thought to be significant in the physician-nurse relationship. One nurse stated that she would like to see physicians "...more as colleagues and [with] less of a need [for nurses] to use psychology" (#14).

The relationship with patients and their families was described as having four qualities: an intense rapport, a nursing presence, development of trust, and a teaching component. The ideal rapport between patient and nurse was characterized as intense, as developing quickly, and based on patient expectations. Many nurses referred to the development of this relationship as "bonding".

> Well, there is that whole bonding thing at the beginning, especially if you admit a patient, to find out about their family...and getting to know them a little bit, and most of the time, they will start asking you questions, too. They want to know who is looking after them. I think setting up to be free for questions from them [is important], that you are open to all their questions and what their plan is. A lot of people have birthing plans written, and they give it to you, so that is something else to consider too, to go through. (#6)

Nurses felt it is important to be right there, to be "present" with the patient, in order to develop the relationship, and then to provide support. Nursing "from the doorway", or "back against the wall" is not acceptable.

> ...you sat beside the patient, and you felt a contraction, okay, there is a contraction

> starting now, relax your body. And you start the process of relaxation and breathing, and there was a nurse sitting by the bedside, holding a hand, feeling a tummy, looking at each other's eyes, breathing with them. (#16)

Nurses felt strongly that their role in the relationship was one of support, but always with the woman's expectations in mind. However, the best support is provided when there is rapport or bonding, as trust in the nurse is developed by the patient.

> ...one of the most important things I can do for my patients is go with their flow and be there for them as a strong point. Like one girl said to me, you were my rock, but allowing them to do basically what they want and getting to know them well enough, having the rapport with them to say, okay, we have done this, but now we have to do this, and in comes the trust and knowledge that we have to know and to be able to talk to our patients that things are going differently than you expected... (#2)

Several nurses commented on the importance of family, particularly partner, involvement.

> I like to see them really involved, and when the father tries to escape because he doesn't know what to do, we bring him back, get in here, and hold her arm or give her a hug. It helps them to know what to do even if it is just wiping her forehead with a cloth...They get uptight because there is nothing they feel they can do. (#8)

Variables Affecting Role Expectations

Role expectations are affected by professional standards, formal education, the organizational culture, each nurse's philosophy of birth, and a culture of L&D nursing.

Figure 4 illustrates the relationships to role expectations.

The organizational culture of the four institutions is illustrated in Tables 3 and 4. Data describing the organizational culture were obtained from Head Nurse/Nurse Managers who completed the Institution Data Collection Form (Appendix H). Information regarding formal education attained by the participants was obtained from the demographic data (Appendix G). No specific questions were asked during the interview about the influence of formal education or the impact of professional standards, and no information was volunteered.

The professional standards for nurses in Manitoba are set by the MARN Act. Any violation of the standards may result in the nurse being disciplined by the professional Association. Role expectations, then, are tempered by what the L&D nurse is allowed to do under the Act. For example, nurses may not legally deliver babies, except in emergent situations. Presently, this is the sole province of physicians, and soon to be the province of midwives. Nurses may not expect that their role would include the delivery of babies. The CNA Code of Ethics also provides guidance for role expectations by laying down ethical expectations for the nurse. These are only guidelines, however.

Nurses did not directly acknowledge the impact of professional practice standards on their role expectations. There was reference to the "ideal" staffing ratios for the L&D unit. The accepted ratios for an active labouring woman is one nurse to one woman (NAACOG Standards, 1991). In discussion of role performance, nurses wished this ratio was followed.

"A lot of times we are expected to do a certain job, and deliver a certain standard of care, and I think that standard is high...we should have a one to one patient ratio"

(#12). There was no reference to who sets the expected standard of care. It could be the professional association or the institution, or the nurses themselves.

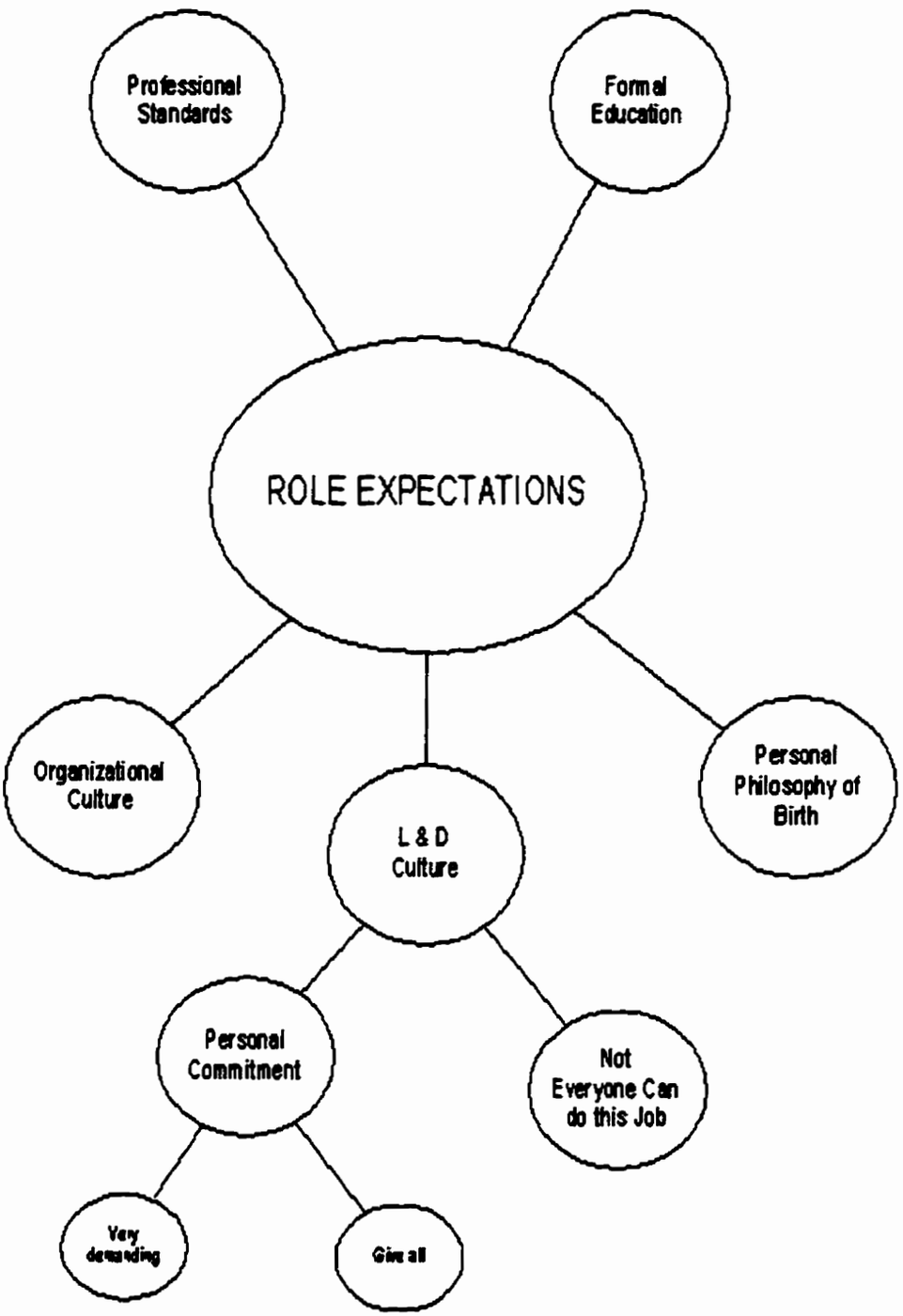


Figure 4: VARIABLES AFFECTING ROLE EXPECTATIONS

No responses given by nurses indicated they felt their formal education had affected their role expectations. However, the formal education of these nurses has probably affected role expectations. Ninety-three per cent of the nurses in this sample had their basic education in a diploma program. Only one nurse had gone on to attain a BN. Irrespective of the type of education, the clinical experience for the maternity setting would have been confined to the hospital. Nurses would thus expect that birth is best done in a hospital setting. This supposition is supported by the majority of nurses indicating, when discussing their personal philosophy of birth, that the best place for birth was the hospital setting. A few indicated that a birth centre would be satisfactory, and only one thought that home birth would be a good alternative. It is difficult to determine whether further education affected the philosophy of birth. However, only nurse who had gone on to gain a baccalaureate degree indicated that the woman in labour had complete authority over her birthing experience. In response to the question, "Is there ever a time when the woman's wishes should be ignored?", she was the only participant who said , "No". All other respondents indicated that when the baby's health and/or life were threatened, the woman's wishes should be overruled. It is impossible to determine whether this attitude was due to further education, or a part of this nurse's life view.

Table 3: Hospital Characteristics

Characteristics	Hospital A	Hospital B	Hospital C	Hospital D
Type of Hospital	Secondary	Secondary	Tertiary	Tertiary
Obstetrical Patients Family Practice Patients	65% 35%	30% 70%	no data	no data
# deliveries 1995-1996	> 2000	> 2000	< 3000	< 3000
C/S Rate	8.6%	2%	17%	20% (approx)
Epidural Rate	27%	2%	49%	30% (approx)
Forceps/ Vacuum Extraction Delivery Rate	9.8%	10%	37.6%	4% (approx)
Syntocinon Use Rate	28.6%	40%	37.6%	No data provided

The nurse participants in this study came from four Winnipeg hospitals: two were tertiary settings and two were secondary (community) hospital settings. As would be expected, both tertiary settings had obstetric and family practice residents. One community hospital had a family practice resident; the other had no resident staff. The tertiary hospitals did not collect data to indicate whether patients came from obstetric or family practice physicians. The community hospitals did collect this data, and they demonstrated nearly opposite ratios. In Hospital A, 65% of patients come from obstetric practices, and 35% from family practice physicians. Hospital B, in contrast, gained 30% of their patients from obstetric practices and 70% of patients from family practice

physicians. These data, on its own, have little significance until they are compared to the intervention rates in the various institutions.

Table 3 illustrates that there are dramatic differences in the Caesarean section rates between community and tertiary hospitals. The community hospitals have rates of 8.6% and 2%; tertiary hospitals have rates of 17% and 20%. This may be reflective of the fact that tertiary hospitals care for more high risk pregnancies which require this intervention. Another influencing factor may be that community hospitals transfer the complicated cases that require this intervention to the tertiary institutions.

Hospital A has epidural rates approaching those of tertiary centres (27% versus 49% and 30% for tertiary centres), whereas Hospital B's epidural rate is a mere 2%. One would expect to see higher epidural rates in tertiary settings where there are more patients who may need this intervention because of increased obstetrical risk or the ready availability of anaesthetic services. Hospital A does not have dedicated anaesthetic services. One might speculate that the differences in epidural rates may be due in part to the much higher numbers of family practice patients that deliver at Hospital B (70% versus 35%).

The operative delivery rates are similar for Hospital A and B (9.8% and 10%), but high for Hospital C (37.6%). Hospital D, in contrast, has the lowest rate of all, at 4%. Again, one would expect to see a higher rate of Caesarean section deliveries in tertiary settings as alternatives to forceps and vacuum extraction deliveries. This supposition does not seem to hold, as the Caesarean section deliveries in the tertiary institutions are very similar (17% versus 20%).

The data about Syntocinon use rate demonstrate no trends between community

and tertiary settings. Hospital D provided no data, but Hospital B and C had the highest rates (40% and 37.6%), with Hospital A slightly lower at 28.6%.

Table 4: Orientation Times in Winnipeg L&D Units

Orientation	Hospital A	Hospital B	Hospital C	Hospital D
to institution	15.5 hours	7.75 hours	16 hours	35 hours
L&D: classroom	15.5 hours	23.25 hours	0-24 hours	35 hours
buddied: clinical teacher	7.75 hours	38.75 hours	8 hours	0 hours
buddied: staff nurse	69.75 hours	77.5 hours	16-32 hours	144 hours
other orientation	0 hours	38.75 hours (for C/S, recovery room)	level 2: 16+16* level 3: 20+28^ level 4: 8+8**	0 hours
Totals	108.5 hours	186 hours	160 hours (minus level 4)	214 hours

*Level 2: orientation to Syntocinon pumps and epidurals; didactic plus "buddied" hours.
^Level 3: orientation to scrubbing and circulating in the operating room; didactic plus "buddied" hours.
**Level 4: orientation to charge duties; didactic plus "buddied" hours.

Hospital A has significantly less orientation time for its L&D nurses than all other institutions. Hospital A does not require the nursing staff to scrub and circulate for Caesarean sections. Adding the time required to learn scrubbing and circulating would make the orientation time comparable with the other community hospital, but Hospital A still has about 30 hours less orientation time. One would expect the orientation time in tertiary hospitals to be greater than that of community hospitals because of the increased numbers of high risk patients the nurse would encounter. This theory does not hold true, with Hospital C having less orientation time than Hospital B (160 hours versus 186

hours). Hospital D offers the most orientation time to its L&D nurses (214 hours). Many more hours were spent being oriented to the institution, than in the other hospitals. Hospital D was the only institution that did not offer its staff clinical time with the clinical teacher. Instead, the "buddied" time with a staff nurse was nearly double that of any other institution.

Only two hospitals, B and D, have a philosophy of birth. Hospital D stated it had a philosophy of birth, but it was not provided to the researcher. Hospital B's philosophy states that labour is a normal physiological process, and identifies the woman as having ultimate responsibility for her health. It is not known how long this philosophy has been in place, nor how or who was responsible for its development. However, all nurses from this institution believed that the mother could be responsible for any decision as long as the baby's well-being was not affected. It would seem, then, that there is conflict between the philosophy of the institution and that of individual nurses.

Nurses in the study described birth as a "natural miracle", a "natural process", and "part of life". If intervention was required, it was to "right the wrong".
As one nurse stated, nurses should

> ...feel it is a natural process, but they also recognize that within nature, things do go wrong and when that time occurs, that is what you are there for. You are there to intervene and try to right the wrong, if you can, and to be very open-minded, not to come with a set of rules, regulations and stipulations as to how this process is to occur. (#12)

This attitude to birth recognizes the naturalness of birth, yet acknowledges the need for some intervention.

There appears to be a culture of L&D nursing. L&D nursing is identified by the participating nurses as a very demanding job, both physically and emotionally. One nurse stated: "...you get off a shift and feel as though you have been through a wringer emotionally and physically sometimes. It is a very physically demanding job and a very emotionally demanding job" (#4). And yet, this sample of nurses have worked a mean of 12.21 years in L&D, with 75% of them working L&D only with their present employer. Although health care reform can be responsible for the lack of movement between institutions, this cannot be the only reason. Once nurses work in L&D, they seem to stay. These nurses have been in their positions for a mean of 9.65 years.

One aspect of this culture of L&D nursing is that nurses said repeatedly that not everyone can do this job. This feeling was expressed by both community and tertiary hospital nurses. Statements which reflect this feeling include the following: "I have a very strong belief that labour and delivery nurses are not made, they are born" (#2), "...some don't get it. Some have a sixth sense almost" (#11), and finally, "...specifically what makes them [good L&D nurses] more effective than others, I don't know. It is just there. It is something" (#10). This strong commitment to this role must be reflected in the role expectations these nurses have of themselves and their colleagues. It appears to be more than just a job. These nurses appear to have made a commitment to the nursing of women in labour.

Perceptions of Role Performance

Nurses had difficulty describing what their job entailed. The initial interview questions were minimally successful at obtaining the detail desired. The interview questions were re-worked and re-worded several times through the data collection phase, to try and elicit more detail. In answer to the question, "What do you do for labouring women?", one nurse responded, "You do everything and anything. There are all kinds of physical care that you would give the woman as well as emotional support and care as well...It just seems like it is too much to even say it all. Where do you start?" (#4). Greater detail was found when nurses were asked about situations where there was conflict with colleagues, physicians and women and their families, or when asked how their jobs could be different. Many times, the situations discussed contained descriptions of role performance.

Role performance was found to have three general themes: professional relationships with nursing colleagues, physicians and administration, patient care issues, and safety issues. Each of these will be discussed in detail. Please refer to Figure 5 for a diagrammatic representation of the relationship.

Professional Relationships

Nurses have professional relationships with three groups of people: nursing colleagues, physicians, and nursing administration. L&D nurses' perceptions of these relationships will be discussed in turn.

Nursing Colleagues.

The participating nurses generally agreed that relationships with other nurses were poor. The nurses from only one institution had no negative comments about their colleagues. Indeed, nurses from three of the four participating institutions had more negative that positive comments. Examples of such comments follow:

> There is a great deal of conflict among the staff. There isn't the supportive network that there should be. Because of the kind of elitist attitude, I don't think I have ever seen anywhere where there is so much back stabbing and gossip, and I am told it has always been like that there. (#14)
>
> Interpersonal relationships are very poor there. There has been a crisis happening there for about three years and it is not going anywhere really. I think each individual is trying to get their head in a space where they can just go and function and do a good job without those interpersonal relationships making it so miserable. (#6)
>
> The only real negative thing that takes away or distracts from that ideal work situation is the inter-staff dynamics, and I think that is more specific to our, well, it is probably anywhere. There are just some people that are not happy anymore...not necessarily with work, but with their own lives, and they bring it into work too much, and it makes it hard. There are a few people that I would sooner call in sick if I knew they were on, that kind of thing and I don't think that is good. It doesn't make for a good work environment and it is not just me. (#10)

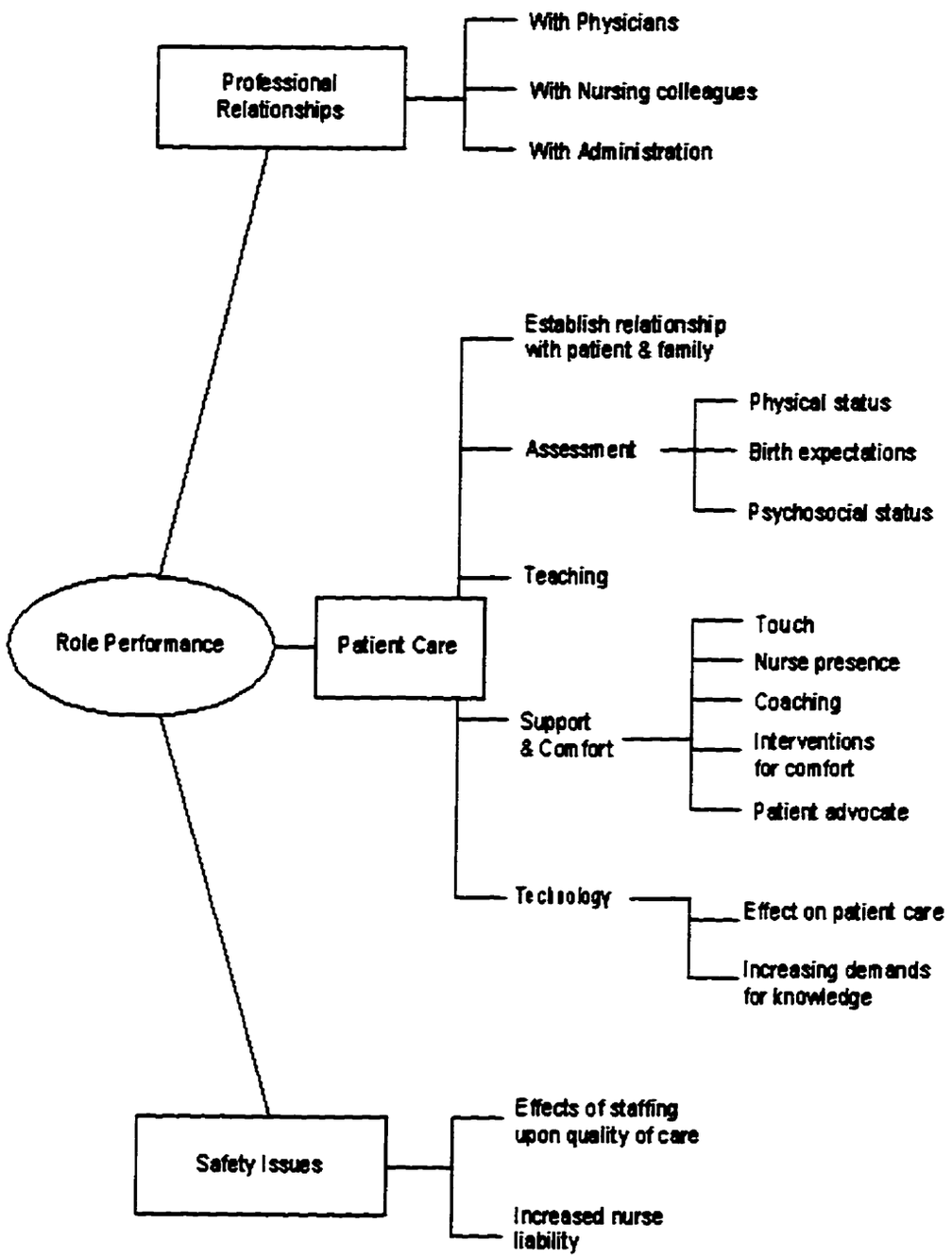


Figure 5: DIMENSIONS OF ROLE PERFORMANCE

Nurses perceived the poor morale and staff relationships as growing out of several factors: resistance to change, bringing problems from home, people on staff have different philosophies about and different reasons for working, not everyone pulls their own weight, and women working together. Examples of nurses' comments follow to illustrate their perceptions: "We are as a whole, unfortunately, and sadly, and it creates the most conflict of all, I think, completely resistant to change" (#14). "I don't know how you expect a bunch of women to ever work together peacefully" (#2).

> Different people have different philosophies about things...they come to work for different reasons. There are women that you work with that come there because it is a part-time thing and they just want to keep their finger in it and it is almost like a hobby to them. There are ones that need to be there to contribute to the family income...there are ones that are there because they are the sole bread winners for themselves...a job, especially nursing, has different meanings for everyone, like the reason why they are there. (#1)

However, some nurses identified that they developed a support network among the nurses with whom they worked. "You cultivate those who have the same work ethic as you do, who probably have the same...background, beliefs and philosophies as you do" (#1). Staff relationships were identified as having a bigger influence on role performance than any other factor. One nurse commented, " [If I could change anything], I think probably [it would be] the people I work with...if I could just choose those, I could just really have a good time" (#6).

All nurses stated they consult their colleagues when they feel unsure about a clinical situation. It is considered the smart and the wise thing to do. "You do at

times...go to colleagues for support to balance things off, to evaluate your own actions...Sometimes, it helps to get another opinion" (#1).

There were institutional differences around the issue of nurse support. Some participants described nurses who provided support by being there, listening and hugging. Others described situations when they perceived a lack of support. "On a lot of shifts, they go in their rooms and they don't come out. You have to ask them to come [out]" (#6).

> We had a patient that was supposed to be induced, and she came in a couple of days from the day they proposed to induce her, and her baby was stillborn. Of course, they [patient and partner] were very angry and rightly so....I happened to be in charge and none of the people that were on that day wanted to look after that patient, which was very hard for me because I couldn't do it myself...it seemed that everybody made everything very difficult for me that day...the person who eventually did get assigned was angry...their anger was also vented a bit on me for giving them that assignment. (#1)

Several nurses commented on the fact that nurses need to work together as a team. Effective team work benefits everyone. One nurse offered a definition of team work: "Everyone has things they do well, and that is what team work does. If I am better at something else, and you are better at something, then as a team we can provide that kind of care for our patients" (#16).

There were positive comments from nurses about their colleagues.

> I never had any expectations of any glamour or anything like that...I enjoy my job. I enjoy the work I do. I still look forward to going to work. I have pride in what I

do. I feel respected by my co-workers. I don't feel acknowledged and respected by some of my bosses...but that is okay because...I have managed to develop good rapport with my co-workers and we support each other, we pat each other on the back when we need to, and I really think that is important. (#3)

I happen to work with a particularly good bunch of nurses. I have known a lot of these girls for a long time. I know what they can do. I know their strengths, I know their weaknesses, I know what they are doing...we have a really good rotation...we have worked really hard at achieving that...(#2)

Nurse-Physician Relationships.

Relationships with physicians were generally perceived as positive and "generally good" (#3). These relationships are thought to be different than they are in other patient care settings. They are more collegial and "side by side". Most of the time, nurses felt their intuitions, assessments and opinions were acknowledged by physicians.

I think they trust my assessment and most of the time they will listen. They may not always agree and they [may] prefer to manage the patient differently, but I really don't have a lot of trouble at this point with them not listening. (#11)

Physicians are seen as being dependent on nurses for accurate assessments, particularly in the community hospitals where there is little or no resident staff. "We are mostly with the patients a lot so we know the patients...they [doctors] sort of count on what we say" (#5). Nurses felt they had to earn credibility with the doctors after starting in a new position.

I find with the nurses that are newer, or if their assessments are consistently

> wrong, there is a bit more hesitancy [to trust the nurse's judgement]. You sort of have to go through these initiation rights. I used to phone a physician...and he used to say, and who else is working with you, dear, could I please speak to them? I think that went on for about five years. I never rated. (#11)

One nurse felt earning credibility was not a negative aspect of the relationship, but rather a positive one.

> I think it is only natural, and I think that is clever on their [physician's] part, not to just give their total trust to someone who they don't really know...Credentials and what a person has behind their name sometimes has nothing to do with if they can do the job. (#12)

A good nurse-physician relationship exists when the nurse can phone the physician, and without pleading, convincing, or cajoling, obtain the order for the treatment she believes would be in the best interest of her patient. An example follows:

> It is a nice relationship when you can phone up and say, you know, I really think so and so needs an epidural. They are kind of losing their mind in there, and they [the doctors] are very open to, okay, I will order an epidural. It is nice when the doctor says well, what do you think they need, and it is a good feeling that they value your opinion. (#7)

For nurses working in the tertiary care settings, distinctions were often made about the relationship nurses had with residents, attending physicians who had been residents in the past, and the older attending physicians. Some found the relationship with residents and younger attending physicians easier because they tended to be open to suggestions and opinions. Other nurses found the relationship more difficult because

"they don't want to think that they are learning anything from nurses" (#9). However, a nurse stated, "A good obstetrician and the ones that are smart give their nurses credit and say thank you" (#16). Some nurses reported that positive feedback is given by doctors, not every day, but particularly after very difficult cases.

Nurses identified that sometimes, there was a need to protect the patients from the doctors, or more specifically, to protect the woman from the application of technology to their labour. Obstetrical residents, some nurses thought, were more guilty of this than attending physicians. As a nurse in a tertiary setting commented:

> I find in a tertiary care setting, [doctors need] just a reminder that we don't have to do all of these things. We have all this machinery, sure we can augment this lady's labour and she will deliver in a couple of hours, but do we really need to do that? I think after you have worked in an institution and [are] able to gain their respect, you can say those things to physicians, and put those ideas in their head in a way that is not too threatening to them. (#9)

Despite nurses' generally positive feelings about the physician-nurse relationship, it was very evident that the "doctor-nurse game", as described by Stein, Watts and Howell (1990), is alive and well in Winnipeg hospitals, as evidenced in the latter part of the previous quote. There were many comments from nurses about the importance of tact and diplomacy when making suggestions. It was better to use a certain tone of voice. Not doing so could "make life miserable" (#2). In one situation, the patient paid the price for a comment her nurse made:

> You hate to think that there is this mind game when you are looking after patients, but I had this woman pushing for three hours and that perineum was bulging for

> an hour...She needed an episiotomy. In the end he [the doctor] had to do one, but he had an intern with him...and he [the doctor] was saying, now we will do a small episiotomy. So I said to the patient, they are going to do an episiotomy and the baby will be out soon. He heard me say that, and he looked at me, and he put the scissors down, and we went for another half hour. Now this is a younger guy...I learned something about him. I am never going to suggest anything, or try to direct. (#6)

Older physicians appear to have different expectations of nurses. They expect more of the hand-maiden role. "The older doctors will expect you to wait on them hand and foot whereas the younger doctors will do their own thing and will ask you for things" (#3). There is some indication that older nurses treat physicians differently than younger nurses. They cater to the physicians and try to anticipate their needs.

> I do get along with them [doctors] very well. As a matter of fact, I sort of cater for them...I came from the old school, so when I come in, their gloves and everything [are] ready for them....I anticipate what they are supposed to be doing...their chairs are there, everything is there for them. (#15)

Conflict with physicians is reported to centre around differences of opinion on management of care and application of institutional policies. Nurses often feel stuck in the middle, between patient and doctor, advocating for the patient when the doctor will not consider any other solution. One nurse reported that the physician puts her in the middle when he refuses to follow policy. "Mostly, it is an avoidance of the policies that put you in the middle. Giving medications that you are not supposed to give...that you are not entitled by policy to give" (#14). A nurse, working in the same institution, and

obviously exposed to the same situations, commented, "Do I have a place to stand and say, no, let's not do this? He will just turn around and get another nurse to start the IV and do it" (#10). If the physician involved is a resident or intern, nurses in the tertiary settings felt they had more options in dealing with questionable order. They would move up the chain of command.

Relationship with Administration.

Nurses perceived administration to be the Head Nurse/Nurse Manager level and above. Often, they would specify by title the Head Nurse/Nurse Manager, but all other layers of administration would get lumped into the amorphous, all-inclusive word, "they".

There was recognition of support from administration from one institution. All nurses interviewed had positive things to say about their immediate supervisor.

> The supervisors let us do our own thing. Our [Head/Nurse/Nurse Manager] is incredible. She will let us do pretty much anything, and we let our patients do whatever they want, unless it is really going to harm the child, and it really is almost an ideal place to work. (#8)

However, this perception of support did not extend to the upper levels of management.

In the other three institutions, the majority of nurses indicated they felt little support from administration. Nurses cited examples of behaviour that led nurses to feel lack of support and only rarely recognition of a job well done. Any tangible recognition was more often supplied by the doctors . "...In that stressful situation, the doctors ordered pizza, and it was like, a pat on the back from our charge nurse, really well done kind of

thing" (#5). In situations of conflict (i.e., patient complaints or conflict with physicians) most nurses felt they had little support from their immediate superior. This person tended to support the physicians rather than hearing the nurse's side of the story. Nurses felt they heard about problems they considered insignificant.

> There are a lot of things that I think you have to take as a [Head Nurse/Nurse Manager] on your own shoulders and say nothing about to me. If someone calls you says there was no name on the Rh blood, and you know it was mine. Okay, [I] have worked here for 18 years, and it hasn't happened really before...I don't think you need to even tell me about it. (#16)

Nurses felt there was a lack of response to problems they had identified on the unit. "Issues where there are personality conflicts have pretty much fallen on deaf ears, and I find that very frustrating" (#3). Nurses felt any suggestions they had made for change, that were intended to facilitate patient care, might be met with a positive response from administration, but that the process was so cumbersome and took so long, that nurses just gave up making suggestions.

> If a patient has epimorph, I thought it would be a great idea if all those patients would have a little sticker on their chart, so that everybody knows [at a glance] who has epimorph...Well, it has to go to the Nursing Committee, to the physician, then who is going to put on the sticker? When are we going to put the sticker on? So by that time, I thought, why did I even think about that sticker? There is so much garbage that you have to go through, so sometimes, you get an idea, you don't even mention [it], because it is not worth the hassles. (#12)

There were institution specific differences. All the nurses from one hospital

expressed major concerns about nursing leadership. Some nurses identified two reasons for problems with their immediate supervisors. First, this person was seldom in the clinical area and nurses felt there was little understanding of the issues. Secondly, nursing leadership was thought to suffer from burnout. "The [Head Nurses/Nurse Managers]...don't work in the area. They don't work with the equipment, and so I think there is not a great understanding ...of where we are coming from" (#6). "I think so many people have been in their jobs just too long...there is a lot of burnout in those kinds of jobs" (#12).

Nurses were asked to identify issues and problems they felt administration or the institution should or could do something about. The major concern of the nurses in this sample was staffing ratios. Nurses felt that more staff was needed to do the job properly. Nurses felt that in active labour, a ratio of 1:1 was ideal. In one nurse's view, improving staffing ratios would have a positive effect on patient care:

> [Improving staffing ratios] would make all the difference in the world...but most importantly for the patients. I can run back and forth between patients all day long, but the amount of quality care they get is directly proportional to how many I have to run back and forth between. If somebody needs me there to sit and hold their hand, the more I have to do, the less time I am going to have to do that. (#14)

Nurses also felt, in all institutions, that there is far too much duplication of charting. Nurses also wanted more support and recognition for the job they are doing, sometimes under extreme pressure. Support and recognition do not have to be expensive, and should not "just happen at Christmas" (#15). It can be a simple as recognizing the stressful times. One nurse said:

> The first of [a particular month] we had 26 babies. That is a horrendous day. It was awful and management said, we were so busy, we were so busy, but nobody actually came to the nurses and said, oh gees, you guys, you worked so hard...we still tried to provide the best care that we could...maybe we didn't have all the niceties that we like to have for all our ladies, but nobody ever comes to you and says, you know, this is really good, you guys did really good. (#9)

A number of nurses indicated they would like to have more financial support for in-service education. The monies for in-service education were perceived by some to support mainly the Head Nurse/Nurse Manager group.

Nurses identified some institution specific issues. In two of the four institutions, they felt that major renovations or completely new units were needed. This would facilitate patient care, and provide physical space for women to be able to labour more comfortably, using some alternative devices such as a birthing ball.

> The physical environment is the pits. You have these tiny labour rooms with all this electronic equipment in the rooms and the epidural, and everything else, and you are constantly reaching over, bending over, underneath, transporting beds. You are wasting so much time and energy just dealing with the physical environment. (#12).

Nurses in one setting identified the need for more flexible scheduling and more part-time positions.

> There are a great deal of nurses my age there, and we're getting tired of working all these nights, and that sort of thing...but the resistance to making any sort of changes to more part-time positions is there. (#9)

Patient Care

The patient care theme had five related sub-themes: the therapeutic relationship with patients and families, assessment, teaching, support and comfort and, working with technology. The relationship with women and their families was described as being very intense, very emotional, and short-term. Nurses from all settings felt they have an impact on women because birthing was a major life change and women often remember every detail of their labour.

> This is a life-long memorable event. Not many people remember the year they had their wisdom teeth pulled or their appendix, but you ask them when they had their child, and they can recall almost every single detail to the minute. I was fully at this minute and I was pushing for this long... (#7)

Nurses felt they were interested, respectful and flexible. Nurses tried to quickly develop a relationship with the woman and family as they felt it helped them become confident in the nurse's abilities and promoted the development of trust. One nurse, when asked to describe her own ideal labour, described the nurse she wanted to care for her this way: "She is open, yet confident. I want to see confidence. My labour and delivery nurse has to have confidence. She has to be my rock. I want someone who can ask me questions, and I can talk and we get rapport easily" (#2). It is important to remain calm and reassuring, no matter what the circumstances, as patients and families quickly sense the nurse's panic. One nurse commented that the ability to not panic was a rare quality:

> They need you to be the reassuring one, ...and you have to let them know through your manner, your voice etc., that everything is fine, and if it is not, to be honest with them and open and say what is going on without scaring them too

> much...The ability not to panic, even if many others are or it is a scary situation ...is a good quality to have...but it is also a rare quality that we find in labour floor nurses. (#9)

A nurse described the effect panic can have:

> ...if I am rushing them [patients] to the OR for something, you are explaining things to them, but you are not running doing it. You are not looking like you are all panicked yourself. I don't think they [patients] tend to get as distressed with it. I don't take them down there [the OR] crying all that often...other nurses will, because all of a sudden they are rushing about and they are not explaining things because they are as panicked as the patient is, and they feed off one another. (#10)

Nurses reported that sharing some of their personal lives with women leads to a quicker development of rapport. It was emphasized by many nurses that it was best to determine what the woman and family's expectations were for the birth experience. Nurses must not put their expectations upon the woman, and must be flexible to adapt to the woman's expectations. Family involvement is important in the birthing process. Nurses described techniques they used to promote family involvement.

> [Fathers] get uptight because there is nothing they feel they can do. So, yes, if you give them specific jobs to do, just help them, and keep reassuring them that this is normal, this is what it is like, and it is okay, and everything is proceeding normally. (#8)

Nurses reported that conflict with patients was not uncommon. The incidents they described were grouped into three themes: conflict with the support people, conflict

arising when labour required interventions that were different from patient expectations, and conflict that arose when the nurse was not adaptable or flexible.

Conflict with support people was the predominant theme. The support person that created the most conflict with the nurse was the doula or lay midwife that accompanied the woman and her partner. Nurses found that the lay midwife would often speak for the woman, and placed herself between the nurse and the woman. The nurse felt that she was unable to develop a relationship with the woman and her partner, and therefore, was not doing her job.

> These people thought she [the coach] was God, and everything had to go through her that we did. It was to the point where the woman, this coach, was standing between me and the patient. I was trying to talk to the patient and she was between us answering all the questions. (#6)

Another source of conflict with lay midwives was when they did procedures, like vaginal examinations, that contravened hospital protocols.

> I did have a patient once whose mother wanted to PV [do a pelvic examination] her...I said [to the patient] ...I will let your mom do as much as she can for you, but there are certain things that I would rather take responsibility for. I walked into the room and this woman [the patient's mother] had just put on gloves and was grabbing the muco...there was a bit of a row...(#3)

A third source of conflict arose when the lay midwife insisted that a certain plan be followed, when it seemed obvious to the nurses involved that it was not in the best interest of the woman. Three nurses, all from one institution, graphically described the same incident illustrating this type of conflict. It had made a lasting impression upon

them.

> It was a lay midwife that was looking after her son's girl friend on the family unit...and she had taken control of the situation and had decided that this patient wasn't going to get anything for pain whether she was screaming her head off or not, and she was a 16 year old and she was completely out of control and I didn't feel that the coaching there was, was supporting this girl...it was just you are going to do this naturally, and that is all there is to it,... it was a very difficult situation. It didn't really [get resolved] not to anyone's satisfaction, not theirs, not the patient's and certainly not ours. This girl's mother was involved too, but was shy and intimidated by the lay midwife. She [the mother] wanted the patient to have something...she knew she [the patient] needed something. The girl was 16 and was living in her [the mother's] home, and she [the mother] gave permission for her to have an epidural, when the patient was screaming, "Help me, help me". Her son [the lay midwife's son] actually physically hit me when we started to move the patient from the family unit to the labour floor. It was very distressful. Certainly, I don't feel like, well, we won. (#9)

Conflict related to patient expectations and interventions primarily focussed on the dilemma of the birthing plan. Women often come with detailed birthing plans that inform nurses of the care and interventions that are desired. Birthing plans were seen by some nurses as the patient's way of trying to maintain control in an uncontrollable situation. The conflict arose when the circumstances of the labour do not conform to the birthing plan.

> Mostly, [the conflict] is with people who come in with very stringent birth plans

> and [who] I don't think are very well informed ...about the consequences....that is where a majority of conflict comes when the labour process requires intervention and it might not go along with what the parents wanted. (#3)

Techniques were offered that would help in resolving or reducing the inherent conflict.

> There isn't anything that I have ever encountered basically, that if you haven't sat down and talked it over, and negotiated, and elicited and provided information when you find out what their attitude is on a particular issue, that can't be resolved...the best thing you can offer them is...to try and ask them to be flexible because you don't know how labour is going to go. (#1)

Another source of nurse-patient conflict develops when the nurse is not flexible, adaptable, or is perhaps unaware of the woman's expectations. This conflict was interpreted by some nurses to be a "personality or attitude conflict". This was not reported to be a common event, but does occur and usually involves the same nurses. "...most of the time, there isn't much conflict between the nurse and the patient. I think, most of the time, the nurses who have conflict with patients, it is a repeated event...and everyone knows who these nurses are...chances are you are going to know who those nurses are that are in conflict with patients" (#12). This same nurse felt that although there were tools available to help resolve this situation (i.e., performance appraisals), they were not used effectively.

Assessment was the second component of the patient care theme. Nurses described assessment as a continual process. Assessment includes physical needs, psychosocial needs, family relationships, birthing expectations and assessment of medical risk. In contrast to the previous comment regarding birthing plans, one nurse from a

community hospital confidently stated,

> I find that people who come in with their birthing plans aren't unrealistic. In fact, it is nice to see somebody's birthing plan because it just goes through things that we all should be reminded that we all do for pretty much everyone. There might be a tiny specific thing that the parent requests. (#13)

Nurses from community hospitals felt that their assessment skills were particularly important. It is the nurse's assessment that dictates whether there is a need to phone a doctor, particularly at night. "The doctors aren't there, we all know that, they don't stick around in the hospital. If we need them, we call them. So we have to be very aware and know what is going on with that patient" (#2). Tertiary hospitals, in comparison, have a physician (usually a resident), present around the clock, so the sense of responsibility for getting the assessment "right" is less acute.

Assessment of the woman's expectations for her labour was thought to be of particular importance as it can set the tone for the whole labour. Many nurses felt that this was the patient's day. It was very important for the labour to go well and nurses should try and make it the best possible experience for them. "It is a special time in everybody's life, and it is nice that you can be there to make it the best experience it could be for them. That is the whole goal in all of this as far as I am concerned" (#6). However, there is some indication that assessment and meeting of patient expectations is not a priority for all nurses. One nurse reported seeing interventions forced on women, and felt such action was related to the generation gap between "old" nurses and "new" nurses in her institution. The old nurses were "...trained differently. They were trained to bow down to these doctors and they do, even if it means compromising the patient's

wishes" (#3). There is some evidence among the participants that supports this theory.

> The patients are demanding. They have this concept of, this is what I want and this is what I am going to get ...You can't even do your job now. They tell you this is what I am supposed to be doing and you have to pause for awhile and say, listen, I think I am here to do this job and this is how I am going to do it. Eventually, you sort of give in to them if [there] really is no harm. (#15)

Teaching was identified as an important part of patient care, but was mentioned more often by nurses in community hospitals. Teaching included patient-specific teaching and interpretation of prior discussions with doctors.

> ...if a doctor comes in the room and talks to them for a while and explains something, I will generally stick around and say, okay, how much of that did you follow, and they will be, well,...you start from square one. If you have explained it three times over, that is okay...I like my patients to be informed. (#10)

Teaching is ongoing, and incorporated into the care. One nurse indicated that, in her opinion, more time was spent teaching and providing support than doing the technical aspects of nursing care. "It is important to know that status of your patient, but a lot more of the support and the teaching are going on than the actual two to three minutes it takes to do vital signs" (#8).

The fourth component of patient care was the provision of support and comfort to labouring women. Most often, the elements of support and comfort were coupled in the conversation. It was difficult to divide them into separate components, as they seem to share many similar elements. Support, to these nurses, means more than just providing for physical needs. It was described as "being there" (#8), being the "voice of experience

for the patient" (#14), helping the coach with coaching (#6), coaching, provision of reassurance, being "the rock" (#2), and advocating for the patient (#10). One nurse felt it was her role to provide support for those women who were unable to meet the expectations they had of themselves in labour. She said, "...sometimes you need to help them forgive themselves after" (#6).

Comfort was also more than the provision of physical comfort needs; it included the provision of psychological comfort as well. One nurse stated, "I make sure that one is comfortable. I make sure that the patient is comfortable in labour, she is comfortable with her surroundings, she is comfortable with me" (#15). It was felt to be important for the patient to have confidence and trust in her nurse, as this promotes comfort. Physical comfort measures mentioned by nurses included being with the patient, ice packs, birthing balls, positions changes, back rubs, liberal use of touch, fluids, snacks, and cots for the partners. Nurses generally felt that close proximity to the woman is essential, as is touching the patient. Touch is seen as denoting acceptance of the patient, but that touch is not for every patient. It is individual, and the appropriateness of touch needs to be assessed. Touch was also perceived as helping the woman stay focussed and in control. Some nurses reported using touch as a comfort technique without even thinking about it consciously.

> It is something I don't think about doing. I just do it. Acceptance, maybe. I don't want to feel like I am assuming that they are going to like me or that I am accepted. You can tell, too, if it is not working, or if they don't appreciate that touch, but I think that most of the time, and a lot of times these kids, we get 13 year olds, 14 year olds, that kind of thing, and they are terrified. If you sit down

> on the bed, and put your hand on their hand, or whatever, and just talk to them at their level, they will understand that you are not really an authority person, you are just a helper for them. (#10)

Some reported that not all nurses get physically close, or like to touch their patients.

> I have seen quite a lot of people that stand up against the wall...and say breathe, take a big breath, come on, breathe, breathe, but at no point are they getting near the patient to let them know they are there for them and help them through. There are quite a few people working in the area that aren't...very tactile individuals. I can't say it is just at my institution because I have been with friends that have had babies at other hospitals, and I have seen of few of those there. (#14)

This nurse felt touch was not used enough: "I don't think I see enough of people sitting on the bed with their arm around the patient, comforting them, or rubbing their backs, or whatever is comfortable for the patient. I don't think there is enough of that" (#14). She was not alone, as other nurses in this sample expressed the same opinion.

The final component in the patient care theme was working with technology. Nurses all acknowledged that this was part of their job. The technology that was mentioned most often are fetal monitors, various types of infusion pumps, and epidurals. For a nurse in a tertiary care setting, there are always new things to learn:

> We are always learning to do more things...like more technical interventions, taking care of ART lines, doing more with infusion pumps for epidurals, so there is always that kind of increased knowledge base for nursing, since you are staying in one sort of one very specialized area, you still have to be picking up new skills. (#4)

The statistics provided by the institutions illustrate the extensive use of technology in Winnipeg hospitals. Some nurses decried the use of technology, specifically, fetal monitoring technology. One nurse said:

> We go way too crazy over the monitoring of a low risk patient. I think the use of monitors are outrageous, and I think for a high risk patient, I am all for strapping them in for the duration, but when somebody is very low risk, I don't think they should be on a electronic fetal monitor constantly, and I think even the use, on a very low risk patient, of a Doptone is almost excessive. (#14)

Epidural rates range form 27% to 49% in three of the four institutions surveyed. Caesarean section rates vary from 2% to 20%. Syntocinon Use rates, for inductions and augmentations, are fairly consistent at 28.6% to 40%.

There were several comments from nurses in all settings indicating how the use of technology has affected nursing care. One nurse indicated that "...we are too intervenionous...we do too much of that [intervene] and take control out of the patient's hands too often" (#14). Fetal monitors are being used too much, particularly for low risk mothers. Lamented a nurse from a tertiary setting,

> ...the nurse that looked after an obstetrical patient 20 years ago, your senses were so different. You heard things when you listened to a fetal heart [by auscultation], you really heard, you knew exactly what was going on. You probably could tell as much as a monitor in one respect...That won't happen any more because there is never going to be that kind of hands on ...It is going to be a lost art. (#16)

Epidurals are seen to be offered too readily, sometimes for the nurse's convenience.

> You have several patients, and you go from room to room to do the basic stuff,

> check fetal heart, check blood pressure, hey how is it going, and instead of offering some encouraging words and sitting for a few minutes with the patient...it is, too quickly, oh, do you want something for pain, do you want an epidural? (#3)

Sometimes, epidurals are offered because of the expectation that women should not have to be too uncomfortable, or be noisy. "You know that everyone [in a particular room] is just going to get an epidural. Because as soon as you hear someone getting uncomfortable, they have an epidural, and then it is quiet" (#13). One nurse gave a graphic description as to how epidurals change the perceived need to be at the patient's bedside:

> Once the epidural is in place,...they are quite comfortable there sitting talking [to their husband or their mother], you don't want to infringe on their privacy because they are quite content, so you tend to stay out...you have to look at two monitors, two Syntocinons, and you are looking from one room to the next, and so the place to sit is in between. (#16)

Safety Issues

Safety was the last theme identified by nurses in the discussion of their role performance. Nurses have concerns about staffing levels and effects that staffing levels have on the quality of the care provided. They want to be able to do the job to the standard they feel it should be done. Staffing levels, considered less that what one should have, acutely affects the sense of responsibility and liability.

> Caring for three people...I am now [taking] responsibility for their welfare and also for their baby. So if they happen to have a "decel", or something like that

> and I am off doing something else, you can't do two things at once and...know exactly to be expected four years later, to go to court and say, well, you know the reason I didn't know that decel was happening is because I was catheterizing somebody...occasionally it does happen, and to me, I feel it leaves me sometimes at great risk, because, there I am, responsible, and there is no human way that you can be in two places at one time. (#1)

Another nurse stated,

> When you have so many patients, you don't do a good job. You don't have the time to do a good job. You do the things you have to do. You make sure the baby is okay...You do the essential stuff, but you don't get to do any extras. You can't be supportive that way. You are just kind of making sure everybody is alive. (#6)

Some nurses feel that more and more is expected of them. Not only do they provide nursing care, but they are expected to teach and be a "buddy". The feeling was, you can't do everything effectively.

> The expectation of you is to deliver this wonderful standard of care, yet the environment that they put you in, you can't achieve it, and then you feel stressed out because you are not doing it, and more and more demands are being put on you all the time. Then, on top of it, maybe you have to buddy with somebody, or teach. So you feel like you are being pulled apart, and that you can't do your job effectively or the way you want to do it. (#12)

There were institutional differences in the safety theme. Nurses from two of the four institutions identified that the skills and abilities of the nursing staff were not

comparable, long after the time when they should have been. This had the effect of increasing, yet again, the remaining nurses' sense of responsibility. They felt they had to make up for their colleagues' weaknesses. It made for perceptions of unfair workloads, and concerns about patient safety.

> We are stretched to the limit some days...I have often been told that you are one of the ones that can handle it, but some days it is frustrating to have to handle it...we have this group of nurses that are "new" because they have just been "cross-trained". They have been there for 3-4 years doing labour and delivery, and well, they can't handle as much so you have to take up the slack, you have no choice. Three of you are working labour and delivery, but not everyone is working 33 1/3 [the work load is uneven]. (#2)
>
> ...a very junior person that thinks they know a lot more than they do, to the point of being unsafe...there are times when you are working with people that is hard. A lot of ones...there are...some that are very near retirement...their skills have never changed. They have never kept up with the changing technology, so that can be frustrating. (#10)

Variables Affecting Role Performance

Variables identified as affecting nurses' role performance were organized under four categories, as identified in the conceptual framework: organizational climate, unit culture, unit climate and personal characteristics. It will be seen that there are repetitions of themes discussed in the role performance. Although the names of the themes may be the same, their focus is not. The content in role performance discusses nurses'

perceptions what their job is. The themes in this section will describe how these same themes may affect or alter the ability of the nurse to do her job in the way she/he would prefer to do it.

Organizational Climate

Organizational climate refers to the individual perceptions and feelings about the organization. Two identified themes which under this heading: the perceived lack of support from administration, and the effect of the physical environment on the ability to provide patient care. See Figure 6 for the diagrammatic relationship.

As was illustrated in the discussion of role performance, nurses felt there was little acknowledgement of a job well done. Too often, nurses would hear only about the "bad stuff". When there were issues of conflict, nurses often felt that administration sided with the other side first, without gathering appropriate data:

> At the general duty level, we do support each other. In the nursing hierarchy...I would say, no, that most of the time they are trying to run away from the situations...rather than standing behind you, and they don't get all the facts first...they make a judgement without even having come and spoken to the individual nurse and getting her side of the story or her perceptions of the event. They might look at the chart or review the situation. (#12)

A few nurses felt they had received positive responses to suggestions they had made about the functioning of the unit. The majority found that suggestions for change

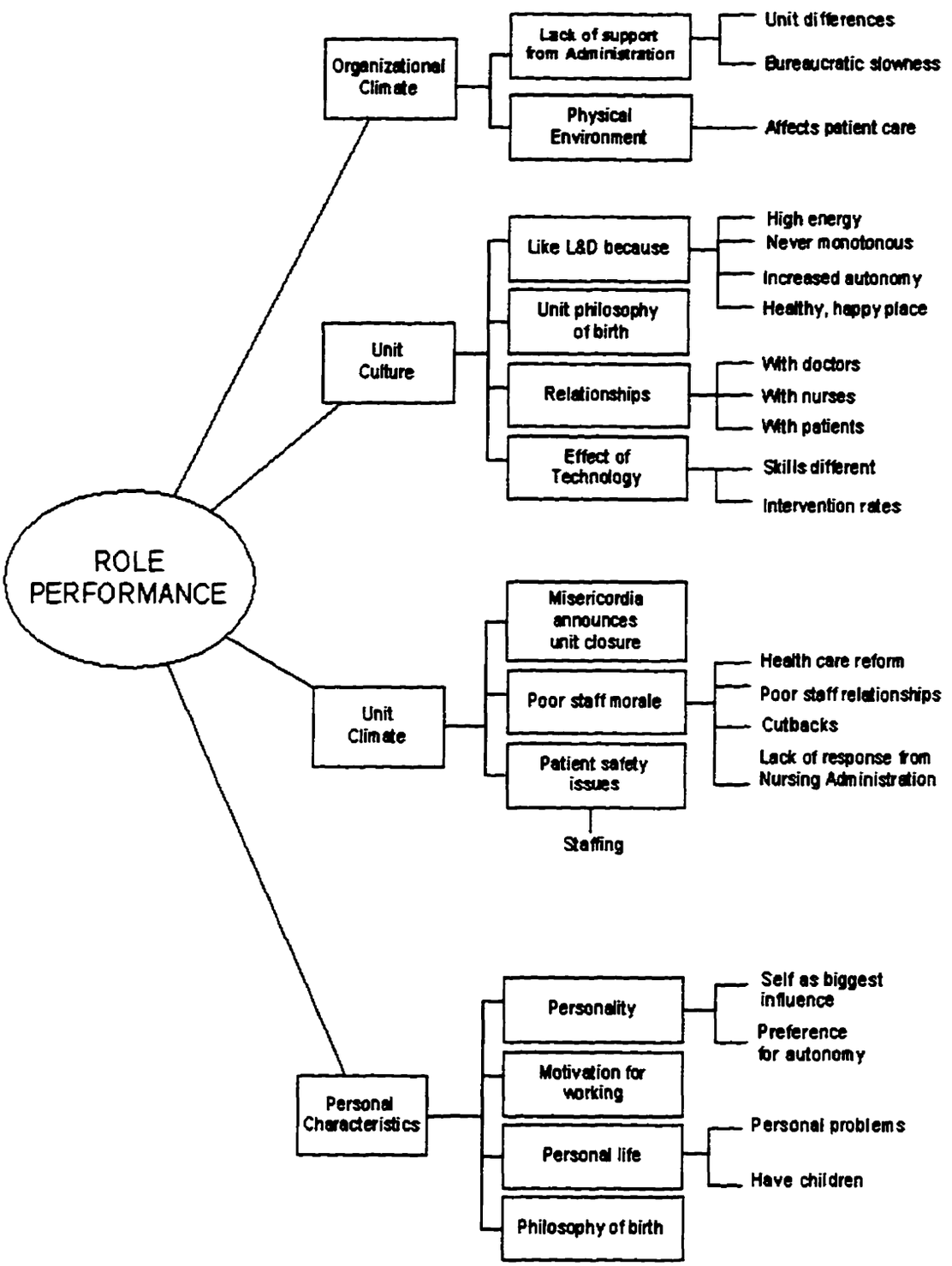


Figure 6: VARIABLES AFFECTING ROLE PERFORMANCE

were ignored, or became so bogged down in the bureaucratic progress that the nurse wished she had never made it.

Administration makes the decisions about staffing levels. Nurses perceived that cutbacks in staffing led to situations where patient safety might be jeopardized, and the nurse felt her/his own liability to be increased. Administration was not perceived, in some institutions, as being responsive to staff concerns about staffing and chronically poor morale. This led to nurses trying to deal with the problems on their own, sometimes circumventing the Head Nurse/Nurse Manager.

> A lot of us have had some conflict with each other. There have been times when nurses are not speaking to each other, and we kind of just decided within our group that we will take the bull by the horns...If there is a problem, we will deal with it. We don't look to anybody. We don't look to management anymore. (#2)

A nurse graphically described the effects that lack of administrative support can have on nursing staff:

> If there is no respect, or if nothing is given to you to kind of reinforce your ability to give, you feel like you hit a wall, after a while, and I think that is where hospital management and administration really falls down sometimes, because much is expected of the caregiver...when they give you a performance appraisal...you are supposed to tell them you have goals...I am supposed to say what I am going to do for you, and you have nothing in return. (#1)

A "good" Head Nurse/Nurse Manager can have very beneficial effects on staff and patient care:

> I think that what makes or breaks the unit is who is running it, how they are

> running it, and if you have a good [Head Nurse/Nurse Manager], I think the staff are going to be heard, they are going to work better, morale will be better, and they will provide care...I think those nurses are going to perform to the best of their abilities. (#3)

Physical environment is part of the organizational climate. In three institutions, nurses felt that the physical environment affected the care they gave, and the stress they experienced.

> The logistics of Children's Hospital and labour floor is a bad scene. A mile apart. You are getting them [doctors from Neonatal Intensive Care (NICU)] there too early and they complain. They don't want to be there. They have a kid crashing in NICU and they are stuck sitting on the labour floor waiting for a baby that is not going to be there for half an hour...It makes our job stressful because we are always trying to read the future, knowing when these babies are going to show up, and you can't do that. (#10)

Unit Culture

There appeared to be four themes in unit culture that nurses saw affecting their role performance. These themes were: the benefits of being a L&D nurse, relationships with physicians, nursing colleagues, and the patients, the unit philosophy of birth, and the effects of technology on patient care. See Figure 6 for a diagrammatic representation.

The nurses interviewed for this study genuinely liked being L&D nurses. There were four main reasons why they liked this clinical area. By far the most popular reason was because it was a happy place, for the most part, and the women nurses dealt with

were basically healthy. These nurses felt they were able to witness the "miracle of birth", of which they never tired. When the question was asked, "what do you like most about being a L&D nurse?", all the nurses smiled, then relaxed back into their chairs. This was something they liked to talk about. "The best thing for me is that nobody is sick" (#12). "Seeing those babies born. That is it. It is exciting. It is a new baby, it is a new birth, the whole idea is just miraculous to me. I love it" (#8). "Seeing dads cry. I love that" (#10).

> The very best thing is seeing that baby born and helping a couple go through the process as best they can and to sort of meet their expectations...then to have a healthy baby at the end is the best, and the ultimate best, for me as an L&D nurse, is to deliver that baby...we don't purposely set out to do it, but it happens. I said the minute...that I don't get a buzz from that, is the day I quit working L&D. (#2)

Nurses felt they had more autonomy and independence working in L&D, than their colleagues in other clinical areas. "I think that probably you get more independence...than you do in many other areas than L&D. For as much as...I wish we had more control...and equality, we certainly get more that many other areas of nursing" (#14). This clinical area is a high energy, challenging area that is never monotonous. "I enjoy working in the area. It is a high energy sort of place...it is enjoyable...[and] challenging...there are always changes going on" (#4).

> You think everything is under control, and all of a sudden 15 things go wrong, or 15 things happen, and you have to be able to pick up those pieces and go back to where you were, and maybe start all over with a different direction,... that is the fun of it. It is not the same old, same old. (#2)

Unit philosophy may also impacts on role performance. In this study, two out of

four of the institutions stated that they had a unit philosophy of birth. Only Hospital B submitted their philosophy. Birth was described as a natural developmental process. Certainly, this philosophy was congruent with this institution's lower rates of interventions. Low interventions rates, however, cannot be completely attributed to the unit philosophy. It is a very complex phenomenon, consisting of physician philosophy and practice styles, the type of patient seen (low versus high risk) and the personal philosophy of each nurse, in addition to the philosophy of the unit.

Nurses felt that the relationships with their complementary role partners affected their role performance. The complementary role partners are physicians, nursing colleagues and the patients.

Relationships with physicians have a large impact on nurses' role performance. Factors that nurses discussed included the personality of the nurse and the physician, and the age of the physician. Older physicians were often thought to expect the nurse to perform the handmaiden role, where as younger doctors were more used to being more independent. "...I think they have to accept that we are busier, and busier, and busier, and they are not going to be pampered the way they were" (#2). Some nurses in tertiary settings perceived the residents to be easier to get along with; others found the attending physicians better. Conflict between nurses and doctors occurred primarily over differences of opinion in clinical matters. Nurses often felt they were "in the middle" between physicians and the patients, sometimes unable to satisfy anyone.

> I would like us to be able to make some more decisions, not to be in conflict when we are trying to support what the patient wants...a little while ago, a patient pushed for six and one half hours, but she wanted to. Her doctor came in

> constantly, and told , "You are exhausted. We have to stop". And she kept saying, "No, I am not, I am fine"...she was doing it, slowly, but doing it. She was placed in a constant position where she felt like she was doing something wrong, and I was in the middle and took the brunt of it, because I was accused of encouraging her when she was too exhausted to continue. (#14)

Nurses seemed resigned to the knowledge that physicians will always test the credibility of nurses they do not know. Several cited examples of how they gained credibility with a physician. Once a nurse gained credibility with a physician, she/he would almost feel like they had "arrived", or were now sanctioned by the best.

> The older doctor walks in, it is in the middle of the night, and unfortunately, he has just missed his delivery. Now initially, he is going to be very pissed off...However, you have just delivered a 10 pound baby and that woman is intact. Well, he doesn't have to stick around to suture. Well, you are right up here [gestured above her head]. It is amazing what makes you credible in these doctors' eyes. (#3)

Nurses in this sample felt their greatest source of support was their fellow nurses, specifically those with whom they had developed more than just a work relationship. One nurse said she found it difficult to gain support from her family members, because they have no understanding of the job or the situation. She stated:

> You go home to your husband and say, "Oh, I had a bad baby". "What do you mean, a bad baby?", he says to me, "It sounds like a quart of bad milk"...he doesn't understand what I am talking about, and the effect it can have on you. Only your colleagues, only those that you work with understand that, and if they

weren't there, I think a lot of us wouldn't be there ourselves. (#2)

Many nurses felt that the consumer's expectations have changed the way they do their job. Women and families now expect the perfect baby. The outcome should be nothing less than ideal: "...people's expectations are that much greater. They demand the perfect baby, and they have a right to the perfect baby, but we all know that, sometimes, that doesn't happen" (#2). Women expect the labour experience to be as pleasant as possible, and have adopted the medical model of birth. There is a greater demand from the women for epidurals, whenever they feel they need them. "An epidural is part of their prenatal classes, and they know exactly what it is all about, and they have their expectations and this is the 90's!" (#16). Sometimes, if the patient's expectations are not met, no matter how unreasonable from the nurse's point to view, it will reflect on the nurse and the institution.

> If a patient says they want an epidural, don't try to talk them out of it because they know what they want...there is almost some repercussion...[if] they think you are not going to let them have one...I remember one incident...it was their second baby, and she was going very quickly and...said she would like to have an epidural. I said I am not sure if there will be time for one...She took the impression that I didn't want her to have one, and she went quickly, didn't get one...she happened to be a relative of someone in administration...it came back that I wouldn't let her have one. (#16).

Most nurses feel that the patient has changed over the years. She is more knowledgeable, and assertive, knows what she wants, and sometimes, how to get it.

> We are seeing a different patient than we saw 20 years ago...Nineteen years ago,

> they didn't have much freedom of choice. We put them in a bed...we orchestrated their labour and delivery. Now, they are orchestrating their labour and delivery. (#2)

The other element that nurses had felt had changed was the greater emphasis on multiculturalism. More patients came from different races and cultures than ever before. Nurses now have to demonstrate cultural awareness to provide quality care for the patient. In response to the question: "what kinds of things do you consider to be essential when interacting with patients and families?", one nurse responded,

> I think mostly just to respect who they are and their cultures as well. Don't put our expectations on them. We get a lot of patients from up north, and even the simple things to us, like go have a shower, they don't even know what a shower is, never mind how to operate it. (#8)

Most nurses felt that the women having control was a positive move in many ways. There was one dissenting voice:

> They come in here and they think they know [it all]. They go [to] six weeks of classes and they think they know all about labour and delivery...I am here for 25 years working [labour and delivery]...People come in and give you a long list [of] what they want to do...they are so demanding right now. (#15)

Most of the conflict between nurses and their patients, was not with the woman herself, but rather with the support person or lay midwife who was the labour companion. There was often discomfort and anger in nurses' voices when they related incidents that had distressed them. The conflict sometimes centred around decisions made for the woman by these companions which, in the nurse's best judgement, were wrong. Another

issue was that the nurse never felt she could talk directly with the woman. There was this other person interpreting for the patient. The nurse never had an opportunity to "bond" or develop rapport.

> She [a midwife and the labour coach] brought a woman in, after 36 hours of rupture of membranes with thick meconium, which distressed me right off the bat, and I had to use a lot of restraint, I was so angry with this woman [the midwife]...These people thought she was God, and everything had to go through her that we did. It was to the point where the coach was standing between me and the patient. I was trying to talk to the patient, and she was between us, answering all the questions. (#6)

Nurses clearly identified the effect that technology has on their role performance. The nursing skills required for a patient in active labour with **no** epidural are very different than the skills required for a patient in active labour **with** an epidural.

> There is much more time just to get them to focus so much, the rubbing the back. You put a lot of physical energy into that sort of thing. It is much easier [to care for a patient with an epidural]. I wonder what our epidural rate is in the middle of the night compared to the day time, because nurses are tired, too, or if you have a busy day, you know you are going to have more epidurals because you don't have the time to spend with the patient, if you have more than one lady you are looking after. It takes a great deal of your emotional energy, too...There are those women that you feel that they want to really try and do this as long as possible without anything, and those take a lot of energy. (#9)

One nurse went so far as to say that nurses who "grew up" with monitors and epidurals

don't know how to care for a woman in active labour with no epidural; they are not used to sitting with her.

> Well, when they didn't have an epidural, you sat beside the patient and you felt contraction, okay, there is a contraction starting now, relax your body, and you start the process of relaxation and breathing, and that was a nurse sitting by the bedside, holding a hand, feeling a tummy, looking at each others' eyes, breathing with them. On epidural, they are on a monitor, the contractions are there, the patient is comfortable, so you do vital signs, you will change a pad, but it is different nursing. So the young people that are being trained with monitors don't have that experience of sitting in rooms, hands on. (#16)

Another nurse, with many years of "hands on" experience put it this way: "...everybody is demanding epidural, and you lost them, they go to sleep on you, and what you do is watch the machine go up and down" (#15). This nurse seem to be referring to the loss of the intense relationship that a labouring woman often develops with her nurse (see role performance). Nurses, particularly those in tertiary settings, may have difficulty changing their focus from technology to the naturalness of the birth process.

> ...where I work, it is very medically based, and I think the idea of taking a monitor away from some of the nurses is just too much for them. They have gotten too used to working with monitors and epidurals, and they are not able to shift that focus back to the mom and the natural birth process. (#9)

Another nurse stated that monitors were used as a kind of "pacifier" and a "safety net" (#10). Nurses who worked in community hospitals identified "tertiary care mentality". A tertiary care mentality to them meant looking for problems, and using all the high level

technology at hand first, instead of the "hands on", low technology approaches. Some nurses working in tertiary care understood the tertiary care mentality, but one nurse had no idea what this meant. The tertiary care mentality, to this person, was how many people you actually knew, and could call by name, in the institution (#10). A nurse from a tertiary hospital admitted, "Can tertiary care nurses be low risk nurses? I am not sure. I think some of them can" (#9).

Unit Climate

Unit climate refers to the nurses' individual thoughts and perceptions about their units. A general uncertainty was expressed by nurses in all units. One hospital had recently undergone another round of bumping. During data collection, another hospital announced the closure of its Birthing Unit effective March 30, 1997. Feelings of sadness and some bitterness were expressed at times during the interviews of these nurses.

Another theme that impacts upon role performance is the generally poor staff morale experienced in three of the four institutions. It was made very clear during interview that, in two of the four institutions, this poor morale was attributed, in part, to the chronically poor staff relationships. Nurses felt poor staff relationships were due to several reasons: resistance to any change at the staff nurse level, nurses bringing problems from home, nurses having different reasons and philosophies for working, not everyone pulling their own weight, and women can't work together. Nursing administration has not, in these nurses' opinions, made any obvious attempt to resolve these chronic problems. It is unclear whether poor morale is the cause of poor staff relationships, or poor staff relationships the cause of poor morale.

As has been illustrated, nurses felt that their efforts were not recognized, yet their small mistakes were always noted and commented upon. Another cause of poor morale was the cutbacks that all the hospitals had experienced, resulting in downsizing and bumping. Staff were continually being expected to do more with less staff.

Nurses expressed real concerns regarding safety issues. Nurses from three of the institutions specifically identified cutbacks as decreasing the ability of the nurse to do the job the way she/he wanted to do it. Comments like "just have to do the basics" (#2), or "need to make sure everyone was alive" (#6), illustrated this feeling. Such situations led nurses to question their legal liability, should anything go awry. In response to the questions, "what can the institution do that would make your job easier, more interesting, or more rewarding?", several nurses identified that having more staff to do the work was the most important to them.

Personal Characteristics

During the interview process, nurses identified themes that were grouped into the category of personal characteristics. These personal characteristics were thought by the nurses to affect role performance. The personal characteristics included: the nurse's own personality, the motivation for working as a nurse, the nurse's personal life, and the nurse's personal philosophy of birth.

There were two elements in the theme of personality: the view of self as the biggest influence on performance, and a preference for autonomous practice. Several nurses felt that the biggest influence on their role performance was themselves. "What you put into it is what you get out of it" was a common theme.

> I think it is just the person I am [that] really has a big influence on how I do my job. I would say that is the biggest thing. Because the person I am is a direct reflection on how I interact with my colleagues, the doctors, the patients and my openness, my flexibility. (#7)

One quality that affects the quality of role performance is the ability to be autonomous and independent. It was thought that this clinical area offered more opportunity to be autonomous and independent than many others. However, a nurse needs to feel comfortable with this expectation. Therefore, it was seen to be a required personal characteristic. "We do have a lot of freedom and a lot of autonomy where I work" (#1). However, being totally independent could have negative consequences. "I think total independence is a dangerous thing on a labour floor. I think you need to know that you should ask somebody else" (#10).

Motivation for working as a nurse appears to influence role performance. One nurse clearly stated that she could identify those whose motivation for working is based on necessity only, rather than on necessity and an interest in the work.

> Nursing has different meanings for everybody, like the reason why they are there...so it affects the attitudes and the methodology in which people work....some people [nurses] are quite contented with sitting back [or] at the desk, whatever, watching their couple...in the meantime, they are quite happy to be doing other things, whether it is reading a magazine, reading the communication book, figuring out their hours; they are not really there. (#1).

The nurse's personal life was seen to affect role performance in two ways: personal problems, and a birthing experience of one's own. Nurses, particularly those

who work in institutions with chronic staff relationship problems, expressed feelings that their co-workers are bringing their personal problems to work with them. This was identified as affecting role performance although how was not specified. There was some indication that staff inter-relationships, rather than patient care matters, are affected. "There [are] just some people that are not happy anymore, they are not happy, not necessarily with work, but with their own lives, and they are bringing it into work too much, and it makes it hard" (#10). "...if they [nurses] are carrying stuff from home, anger from home, that happens, and some people don't really care about bringing their stuff to work. But to me, I really don't think there is a place for it there" (#1).

Some nurses felt that a birthing experience of one's own affected role performance. One nurse specifically felt it helped her become a better nurse. Another nurse felt it improved her empathy. "I think that I have become a better nurse in having had a child myself now. I thought that I was okay as an L&D nurse before, but I think feeling what they feel and having felt that, I feel that I am better now" (#7). "I have laboured with hundreds, but until you have been there, you can't say. I really firmly believe that" (#1).

Philosophy of Birth

The original interview question, "describe your philosophy of birth", was too general. Nurses had difficulty trying to determine what would be involved in a philosophy of birth. Therefore, specific questions were developed that assisted nurses with the elements of a philosophy of birth. Such questions included: who should have control in the birthing experience, the woman, the physician, or joint control; where

should birth take place; who should be the birth attendant; is labour pain a positive experience; and what kind of pain relief should be offered; and finally, where would you place nurses on a continuum scale of intervention. See Figure 7 for the diagrammatic relationship.

Most nurses believed that the woman should have control of and the decision making power about the labour up to the point that the baby's well-being appeared to be in jeopardy. At that point, nurses felt that the woman's wishes should be ignored. The physician should take over control of the labour and do whatever needed to be done to ensure the health of the baby. They felt that women should trust the doctors to make the right decisions for them at this point. "They [women] have to trust their doctor. In the end, this is who in running their show" (#6).

A few nurses felt that control of the labour should be a joint effort, between nurses, women and physicians, or women and physicians. Some nurses felt that at the end of labour, physicians should take more control because women aren't able to make very good decisions.

> Women don't think well at the end. Their bodies are out of control. They have no control and their thought processes are being hindered by the pain they are going through...ultimately someone else pretty much has to call the shots here. (#11)

Only one nurse felt that only the woman should be in control. Even if she was making a decision that could be potentially detrimental to her baby's well-being, the woman's wishes should be honoured. This nurse emphasized the importance of educating the woman so she would be able to make good decisions.

Any patient needs to be in charge. They should be able to make the decisions. If I can make the decision that I don't want to do anything to prolong my life, then I should be able to make the decision as far as my baby is concerned. I may not agree with that woman's decision, but she should have that right to make those decisions and I need to deal with my own judgement calls and it is tough. (#9)

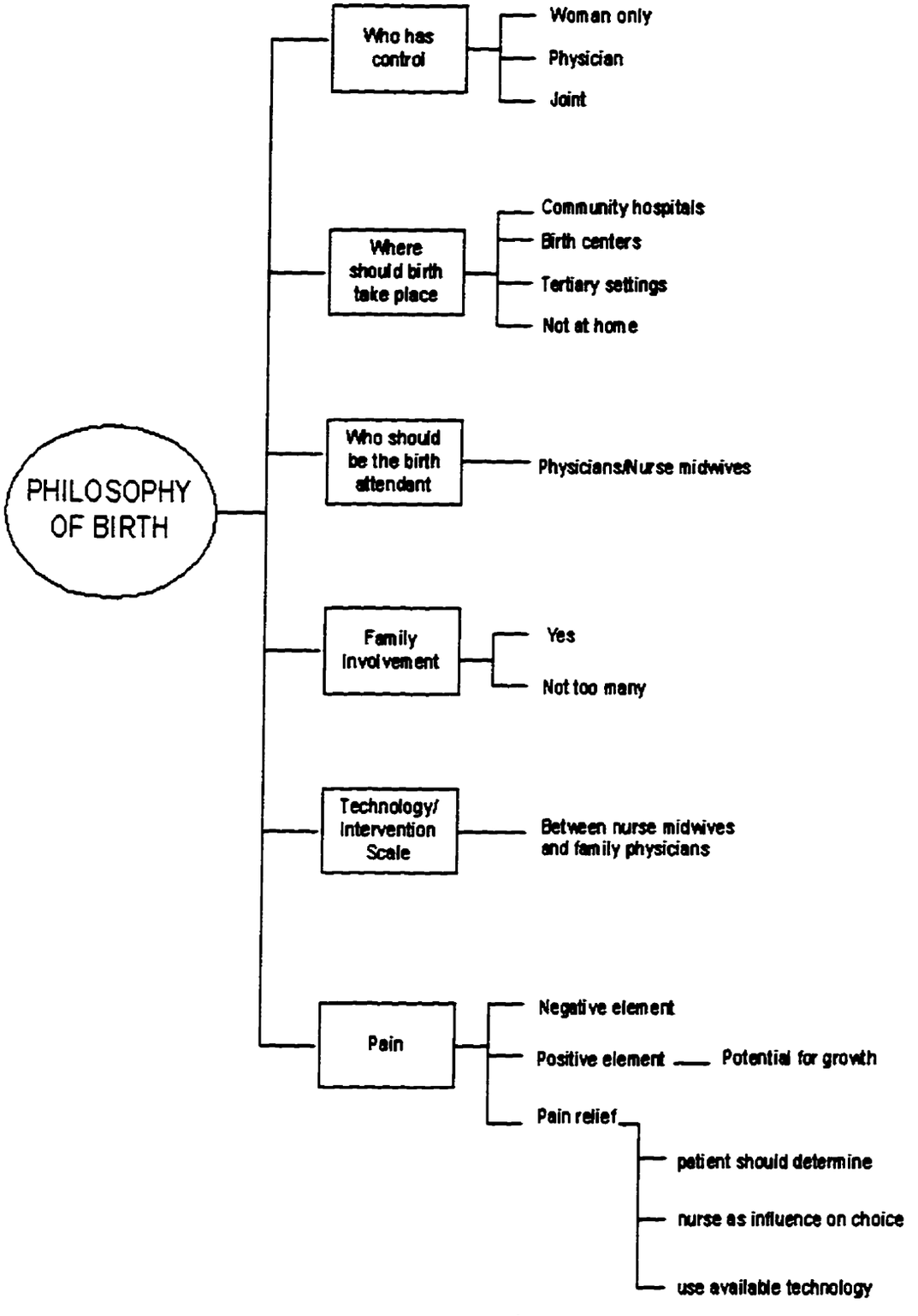


Figure 7: PHILOSOPHY OF BIRTH - L & D NURSES

Nearly all nurses agreed that birth should take place in a hospital, not at home. Although birth centres are not presently an option in Manitoba, some nurses thought this would be a viable alternative to hospital birth. There was a difference between tertiary and community hospital nurses. All community hospital nurses agreed that low risk birth should take place in community hospitals and women with problem pregnancies should deliver in high risk centres. These nurses felt that a low risk woman is best cared for in a community hospital as normality is the expectation. They thought care was more personal, with less people involved in the labour and delivery.

> I think the birth should take place in a community hospital in the most home-like setting that you can have...tertiary [hospitals] look for problems, and it is usually totally chaotic there, and you have more physicians poking themselves at you than you will ever want in your entire life...residents, nursing students, the interns, medical clerks, they are all in there. (#11).

Some tertiary care nurses felt that the best place to give birth was in the tertiary setting because to do so was like "an insurance policy".

> I believe in tertiary care...but tertiary care doesn't have to be a place where women are going to come and have all their rights taken from them,... and having all these people poking and prodding at them...if you have the right physical environment, like a warm, homey, nurturing environment for women to come and bring their families and deliver their babies, and that we are there kind of as an insurance policy...nursing, the tertiary care, medicine, everybody that is there. The team. We are there if things start going wrong, or things are happening that shouldn't be,...we are there to provide them with knowledge and the medical care

to help them out in those situations. (#12)

Most of the nurses in the sample did not express definite opinions that one type of provider is better than another. Obstetricians, family physicians and nurse midwives were all mentioned as ideal birth attendants. Surprisingly, a number of nurses felt nurse midwives would make good birth attendants for low risk women, only. One nurse wanted the obstetrician to do the delivery, but wanted the nurse midwife to provide labour care because she would be compassionate, and would know how to care for the woman (#5). There were no differences between community and tertiary nurses on this issue.

Nurses felt that having a support person, whether a friend or spouse, was of great benefit to the woman in labour, and contributed positively to the woman's experience. However, most nurses were perplexed as to why women would want extended families and children at their labour and delivery. These nurses felt the woman did not receive as much support with more people present.

> I find larger groups of people cause more problems. It takes away from the patient because they are not really there to support the patient. They are there to visit among themselves, and consequently, she gets neglected almost....they [patient and her husband] never get their moment. (#11)

Nurses were asked to place themselves and their nursing colleagues on a continuum scale (from 1 to 10) of intervention. The numerical ratings were not empirically determined. Rather, a numerical value was assigned to facilitate nurses' ability to use the scale. This continuum is described in detail in the conceptual framework (See Figure 1). Lay midwives would be found at the lowest end of the scale,

at 1, as they would use passive support only. Nurse midwives are at 5, as they use more active support and have the expertise to use some interventions, such as episiotomy and fetal monitoring. Family physicians would be found at 8, as they have much more access to interventions (eg: medications to augment labour, limited use of forceps), and the ability and training to use these techniques. Obstetricians are found at the top of the scale. They have extensive training in normal and abnormal pregnancy and labour. They also have the knowledge and training to use any technique that may be required to deliver a baby (eg: mid forceps, Caesarean sections). Thirteen nurses were asked to place themselves and/or their colleagues on this continuum. One nurse refused to participate, saying nurses are not interventionist. "We have beliefs about it [interventions]...we have a role to play when the intervention is sometimes carried out...but we don't do the act" (#12). The question posed to other nurses was then reworded to address beliefs about interventions. Most nurses rated themselves between 5 to 7. A few rated themselves with family physicians.

Table 5: Location of Nurses on a Continuum of Intervention

Location on Continuum	Frequency of Response
5	6
6	1
6.5	2
7	0
8	3
Mean	6.08

One nurse admitted, "We might intervene faster than maybe a family physician, too, then. I think maybe we see things" (#16). This same nurse stated,

> [We] prepare them [patients] for what is going to come up...We do it all the time and even the residents will say to us, "Do you want to start talking about augmentation because I think it is going to happen?"...We pretty well tell the obstetricians when it is time. We call them and say, look it has been so and so, and she is not progressing. Would you like to augment?...On that scale, we are the ones that decide on interventions...we probably decide more than anybody. (#16)

It appears that nurses have different beliefs about how they interpret their role with regard to obstetrical interventions.

Pain in labour was an issue that nurses did not agree on. Most of the nurses felt that pain in labour had more negative than positive connotations. This was not a

unanimous opinion. Some nurses felt that the pain of labour was natural, and could have positive elements to it. One nurse, in particular, felt that women could learn and grow from having experienced and managed the pain of labour.

> [Pain in labour] is a necessary thing...I think women are a lot stronger than they give themselves credit for. They need to be guided in that way sometimes, and [we need to] help them to recognize that you do have strength, that there is nothing wrong if you choose not to use it [sedation, epidural] without making them feel guilty. You learn a lot about yourself...I think it [pain] is a growing part of a woman's life...it makes you wonder in 100 years time, what kind of women we will have if we are not willing to take any sort of discomfort. (#9)

With regards to pain relief in labour, many nurses felt the woman should determine what kind of pain relief she should have. Several nurses felt that if the technology for pain relief was available, there was no reason why it should not be used. "I use the technology that is there. It is there, why not use it..." (#10). Nurses identified several influences that may promote the use of epidural for pain in labour: the public has bought into the medical model of birth, sanctioning the use of technology. In addition, other women tell horror stories about their own labours, scaring those who are yet to deliver, finally, physicians are going to some prenatal classes, promoting the benefits of "walking" epidurals.

> I think a lot of the public have bought into the medical model, and they hear so many horrendous stories, and I think women are bad for that. They are always, my pain was worse than your pain, and my labour was longer than yours...Now with the walking epidural, we have physicians that actually go to the prenatal

> classes, and they are really promoting these, they are not just educating, this is wonderful, this is great, you can get up and walk, and you have no pain. I don't think that is necessary. I think you have to remember that is a very invasive procedure... (#9).

Nurses, too, have some influence over women. If a woman is undecided about managing the pain of labour, she will often ask her nurse for advice. The nurse, not the doctor, is most likely to be at the bedside. The nurse's personal attitudes and beliefs influence, even unconsciously, the advice she might give. One nurse who has not had a birth experience stated:

> ...to be honest with you...looking at second stage, the best way to do that is to have an epidural, so that you are totally frozen, and you don't feel any of that burning, because...there isn't any nice way I can think of to go through that...like when you have half a head out,...that just looks like it hurts like crazy. (#1)

Summary

This chapter has discussed results of the data analysis. Nurses described their role expectations, and the personal and professional attitudes and behaviours required of the ideal nurse. Several variables have been described as affecting role expectations. These include organizational culture, unit culture, personal philosophy of birth and, unexpectedly, a culture of L&D nursing. Role performance was found to have three themes: professional relationships, patient care and safety issues. Role performance was affected by four elements: organizational climate, unit culture, unit climate and personal characteristics. A philosophy of birth was described by nurses, and included issues of

control in labour, place of birth, the ideal birth attendant, family involvement, beliefs surrounding technology and intervention, and beliefs about pain relief. How do these results compare to the information found in the literature? How do these results impact on the introduction of the profession of midwifery in Manitoba? What implications are there for further research?

Chapter 6 Discussion

The last research question, "what is the philosophy of birth of L&D nurses?" will be discussed first. The philosophy of birth impacts both role expectations and role performance. A discussion of the philosophy will clarify the discussion of the variables affecting role expectations and role performance.

Philosophy of Birth

Nurses in this study tended to describe a medical model of birth rather than a midwifery model. Control was ultimately perceived to be the physicians', particularly when there was a perceived threat to the health and well-being of the fetus. The fetus, then, is being treated and perceived as a being separate from the mother. The mother is a vessel containing the fetus. The midwifery model views mother and fetus as a unit, whereas the medical model views mother and fetus as separate entities. Surprisingly, nurse-midwives were thought to be ideal birth attendants, as were obstetricians and family physicians. Pain was generally perceived to be negative requiring active management. The ideal place of birth was thought to be the hospital, although birth centres were satisfactory for low risk deliveries. Finally, nurses placed themselves between nurse-midwives and family physicians on a continuum scale of medical intervention.

Factors that may have had some role in nurses developing a medical model of birth include: formal education, place of work, organizational culture, and unit culture. All nurses in this sample had only the clinical experience gained in hospital settings. This is the only setting legally available for birth, both now and when these nurses

entered their nursing program. They only have had exposure to the medical model.

Place of work appears to have an affected the development of a philosophy of birth. In this sample of nurses, 75% (n=12) had only worked in one L&D unit, the one they were presently employed in. Nurses generally have not had any exposure to another way of practising nursing. Community hospital nurses believed community hospitals were the most appropriate for low risk birth. Tertiary care nurses generally believed in tertiary care for everyone, low and high risk.

Organizational culture also has affected the development of a medical model of birth. The high epidural rates, from 29-49% for three of the four institutions, have become a common practice. Nurses commented on these rates, indicating that a high census might lead nurses to encourage women to have epidurals. The nursing care of an active labouring patient **with** an epidural differed significantly from a patient **without** an epidural. Nurses offered dramatic descriptions of the differences. The medical philosophy of physicians may also have an effect on nurses' philosophy, and definitely affects role performance. For example, Hospital D has very low rates of intervention for forceps and vacuum extraction deliveries. This is probably due to a systematic effort by physicians to reduce the rate of forceps deliveries. Nurses will know this and direct their nursing actions and teaching with patients away from forceps deliveries and toward Caesarean sections or vacuum extractions. Syntocinon rates are high in all the institutions. This is due in part to a change in medical philosophy to consider any patient over 40 weeks gestation as a post-term pregnancy, rather than the previously accepted gestation of 41 weeks.

Orientation of nurses to the L&D unit, and the format of the orientation may have

an impact on the development of the philosophy of birth, particularly if the nurse is coming to her first position in L&D. She/he then becomes a "novice" nurse again, as she/he has little experience with the goals and tools of patient care (Benner, 1984). The novice nurse is socialized to the unit (Rubin, 1988) through interaction with the clinical teacher and staff nurses. There is a very limited role for the clinical teacher in Hospital D; the clinical teacher in this institution is responsible for only the didactic portion of the orientation. The clinical time of the novice is spent with a "buddy". This "buddy" nurse may spend the time, unconsciously perhaps, teaching the novice "our way" of doing things rather than following the institution or unit policy and procedures. Kramer (1974) has described the socialization process of the new graduate in great detail. "Our way" indicates the way nursing care has developed on the clinical area. It may not be the most current, or most efficient way of giving nursing care, but it is "our way".

Unit culture may also impact of the development of a philosophy of birth. Hospital B had a unit philosophy of birth that supports patient decision-making, and the supportive role of the nurse. This institution had a low epidural rate (2%), and low intervention rates as well. No other institution submitted, or had developed a unit philosophy of birth. Their intervention rates were quite dramatically higher, by comparison. One cannot assume that intervention rates are determined by the existence of a unit philosophy of birth. Intervention rates are a very complex phenomenon with many influencing factors. However, the development of a unit philosophy of birth that has both nursing and medical input and consensus, serves as a guide to the provision of care to labouring women.

In conclusion, there is potential conflict between midwives and L&D nurses due

to the perceived differences in birth philosophy. Midwives may feel that longer labours are more "normal", that women moaning with pain is "normal", and that the woman controls decisions about the course of action for herself and the fetus. Nurses, with their belief in a more medical model, may feel that early interventions are appropriate, that epidurals should be offered if the woman is moaning with pain, and that if the baby appears to be compromised, the physician should do whatever is required, perhaps overruling the woman's wishes. Conflict seems inevitable.

Role Expectations

The data demonstrate congruency between the ideal nurse behaviours and role expectations outlined in the literature, and job descriptions and consumer expectations. There appears to be a holistic element, to the assessment of the woman and her family. Culture, socioeconomic status, family structure, childbirth expectations, and other psychosocial factors all should be assessed, according to the nurses in this study.

Generic nursing roles identified in the literature included caregiver, communicator, teacher, counsellor, leader, researcher, and advocate (Bobak, Jensen & Zalar, 1989; Taylor, Lillis & Lemoine). Nurses in this study identified the roles of caregiver, communicator, teacher, counsellor, and advocate. Leader and researcher roles were not identified, but no questions were asked to elicit these roles.

Although the nursing process is mentioned in all job descriptions, only one nurse identified this as a skill that was needed to provide nursing care. This may be because this skill is so ingrained in the expert nurse, that it is not consciously considered. Certainly, the job descriptions emphasize professional care, intra-professional

relationships and the active involvement of the patient and family in decision making. These elements are echoed in these data as well. There is congruency between the elements of the job description and how nurses perceived their nursing role.

The NAACOG Standards (1991) outline the minimum requirements for nursing of intrapartum women. Nurses were expected to be knowledgeable, and have the appropriate clinical and assessment skills. The nurse should also involve the family and act as the woman's advocate. There is congruency between these formal role expectation guidelines and the role expectations identified by L&D nurses.

Three studies in the literature review considered the consumer's expectations of the L&D nurse. Mackey and Locke (1989) found the composite nurse to be calm, compassionate, considerate, understanding, and interested in the woman as a person. These factors were all mentioned by the study group and are grouped under personal behaviours and attitudes. Women had seven categories of expectations of the nurse: presence, decision-making, assistance, physical assessment, information, comfort, and support. Again, all these items are identified by the participants as being necessary in the ideal nurse. Nurses also identified that women varied in their requirements for nursing care, reinforcing Mackey and Locke's (1989) findings.

Mackey and Stephans (1994) had a group of women (N=61) evaluate the L&D nurse following delivery. The five highest ranked favourable evaluation themes were: participation (80%), acceptance (78%), information giving (75%), encouragement (65%), and presence (53%). Unfavourable evaluations included presence, information giving and "manner" of interaction. The authors concluded that interpersonal skills were important for the nurse. Nurses in this study felt that interpersonal skills were most

important, and talked much more about these skills than about technical skills. The manner of the ideal nurse was also more important than technical ability.

Bond, Keen-Payne and Lucy (1995) described the ideal nurse as knowledgeable and competent, accepting, caring, and being continually present. Again, this is the description this group of nurses gave as the ideal nurse. This study is congruent with others in their descriptions of consumer expectations and nurses' descriptions of the ideal nurse. This group of nurses also agreed with Kinney (1985) that nurses need to change their role and how they interact with patients to better meet the needs of individual patients. Adaptability to the woman and family was stressed in the nurses' description of the ideal nurse.

In conclusion, there is no role ambiguity in the role expectations of the L&D nurse. There is, however, role overlap with many elements of the midwifery role expectations.

Variables Affecting Role Expectations

Nurses described three themes that affected their role expectations: philosophy of birth, organizational culture and L&D culture. There was congruity between tertiary and community hospital nurses as to how they perceived the ideal nurse. Holism is highly valued by these nurses. However, this is contradicted by their general philosophy of birth which favours a medical model rather than a midwifery model. Generally, psychosocial qualities were considered more valuable than technical skills. Patient advocacy, teaching and communication skills were highly valued. Nurses recognized the importance of family involvement and assessments that incorporated the psychosocial and physical

domains. This appears to be influenced by a variable not identified in the literature - a culture of L&D nursing. Organizational and unit culture appears to have an impact upon role expectations, particularly with regard to the use of technology. This reinforces the findings of Thomas et al. (1990), Mitchell (1994), Dabney (1995), and Chaska (1992) who found that unit and organizational culture affects role expectations and role performance. There were small differences between community and tertiary nurses. Philosophy of birth affects role expectations as well as being affected by organizational and unit culture. Formal education and professional standards were not mentioned by nurses as impacting on their role expectations. This could be because no specific questions were asked about these variables as factors, or because nurses do not perceive these variables as affecting role expectations.

Role Performance

Although nurses had difficulty describing what their job was like, there is no doubt that they understood what the job entailed. The difficulty of the description probably relates more to the amount of detail involved, and the level of expertise of the nurses interviewed rather than the knowledge of the job. Benner (1984) states, "...it is *not* possible to recapture from the experts in explicit formal steps, the mental processes or all the elements that go into their expert recognitional capacity to make rapid patient assessments" (p. 42). Role ambiguity was not found.

Four of the five themes identified in the patient care theme (relationships, assessments, teaching, support and comfort) correspond closely with the role expectations found in this study, and others as well. There is also congruity with consumer

expectations for the L&D nurse as discussed by Mackey and Locke (1989), Mackey and Stepans (1994), and Bond, Keen-Payne and Lucy (1995). These elements, nurses felt, were more important in their care, than the requirements for technical expertise. This does not imply that technical expertise is not important, but rather that it is more easily developed than the psychosocial behaviours and attitudes which were described as "inborn" and "intuitive". Nurses felt that psychosocial behaviours and attitudes were much more important that technical skills. If this is so, one would expect to see, in the care provided, more emphasis on support and comfort measures. However, research studies that have investigated what nurses actually do and say (Beaton, 1990; McNiven, Hodnett, & O'Brian-Pallas, 1992) contradict what this group of nurses say they do. Beaton's study (1990) determined whose definition of labour predominates, the nurse's or the patient's. Nurses were found to presume what women were experiencing, and did not "hear" what she was attempting to say. Mutual decision making was rarely found. Decision making was very similar to the classic physician-patient relationship. Beaton's study was done in Winnipeg, and more than likely involved some of the nurses interviewed for this research study. Another Canadian study by McNiven, Hodnett and O'Brian-Pallas (1992) examined the proportion of time nurses spent in supportive care activities. The definition of support incorporates the themes found in the patient care theme of this study. The average amount of time spent in supportive care activities was 9.9%. The greatest numbers for supportive activities were in the domains of instruction and information, with virtual absence in the domains of physical comfort and advocacy.

Who is right, the studies with its objective measures or the perceptions of nurses? The only way to accurately measure nurses' perceptions would be to study these same

nurses using a technique like that of McNiven, Hodnett and O'Brian-Pallas (1992). The technique would have to be modified somewhat to include an equal number of patients with and without epidurals. Certainly, the results of this study indicate that epidurals have a great impact on the type of nursing care required. McNiven, Hodnett and O'Brian-Pallas (1992) recorded an epidural rate of approximately 80% and a Caesarean section rate of 23.5%. Epidural rates in Winnipeg range from 27-49%. If a patient is comfortable because she has an effective epidural, additional comfort activities are not likely to be offered. Likewise, patient advocacy activities may not always take place at the bedside, and therefore, may not be observed. Nurses in this study reported patient advocacy taking place over the telephone and outside the patient's room as well as at the bedside. Advocacy will more likely occur if the nurse has a reasonable expectation that the physician will compromise. Such compromise may depend on the nurse's communication skills, the type of relationship the nurse and physician have, the credibility of the nurse with the physician, the organizational and unit culture, and the nurse and physician philosophy toward birth. These factors are not discussed in the McNiven, Hodnett and O'Brian-Pallas (1992) study. In conclusion, patient support measures are a complex phenomenon. Noting their presence or absence is but a start to examining this complexity.

Nurses in this study were cognizant of nurse-patient conflict due to personality or attitude conflict. The nurse in conflict with the patient was thought to be inflexible, not adaptable to the patient's wishes and desires, or even unaware of the woman's and family expectations. It was usually the same nurse(s) who appeared to be in conflict with women and families. This supports the finding by Mackey and Stepans (1994) that

negative evaluations were given by patients of their L&D nurse, in part because of the "manner" in which the nurse interacted with the woman and her support person. The perception of this sample of Winnipeg nurses is that nothing is done to correct the behaviour of the nurse who is inflexible and perceived to be creating conflict. Do the supervisors of a unit know that this is a repeated occurrence? Do nurses make their supervisors aware of such behaviours? If the answer to these two questions is "no", then this behaviour will be perceived as acceptable by the involved nurse and her colleagues. If the situation is not corrected, it is ultimately the woman and family and unit morale that suffer.

Nurse-physician relationships are a role performance theme, and also impact on role performance. Although nurses felt their relationships with physicians were generally good, and most stated they felt little reluctance to advocate for the patient, it is very obvious that the doctor-nurse game is still being played. Nurse-physician relationships were described as being collegial, and different than any other clinical area. The nurse, however, needed to be careful how she/he suggested or said things. Not to do so would result in punishment of the nurse and or the patient. True collaboration, then, does not exist as the nurse's judgments and recommendations for care cannot be simply stated. The recommendations must be formed into statements that are palatable and acceptable to the physician. "Fragmentation of care, buck passing, and lack of holistic care are logical outcomes of systems that highly regulate which professionals may perform set practices, independent of the patient's pressing problems and independent of matching knowledge and skills to patient need...the ability to benefit the patient is restricted" (Storch, 1994, p. 547-8). Storch (1994) identifies several strategies to enhance collaboration: development

of mutual trust and respect, and valuing the expertise of each discipline, modify the educational process to allow opportunities for dialogue and mutual decision making, changing institutional structures and processes that emphasize ownership of the patient by the physician, and giving equal power to all health team members to influence decisions relating to care giving. Some of these suggestions are ideal for a quality improvement program. In such a setting, the development of trust and respect may continue. Nurses, after all, did report that relationships with physicians in L&D are different, better and more collegial than in other clinical areas.

Poor peer relationships, as well as nurse-physician relationships have been identified in the literature as sources of stress and job dissatisfaction (Bush, 1988; Gray-Toft & Anderson, 1981; Haydon, Davis & Clore, 1982; Hipwell, Taylor & Wilson, 1989; Tri, 1991; Tumulty, Jernigan & Kohut, 1994; Ward, 1986). Nurses from two of four Winnipeg L&D units revealed problems with morale and poor collegial relationships. This study cannot elicit which factor is the cause or which is the effect. In one institution, administration is perceived as so ineffective that nurses circumvent the Head Nurse/Nurse Manager in favour of more informal solutions. These informal solutions may solve the immediate problem, but it does little to solve the larger problem which involves all the staff. Poor nursing relationships cause stress and job dissatisfaction. Winnipeg L&D units are not immune. Are poor staff relationships an accepted factor in nursing? Is it something that one has to live with? One factor cited as a cause of poor morale in this study was the perceived inability of women to work together. This factor can be dealt with, given some time and financial commitment. Institutions need to ascertain what the reasons are for poor relationships, and be proactive in helping the staff solve the

problems, particularly in those units who report chronic problems.

Nurses reported concerns related to their personal liability as they perceive staffing levels to be less than what is required. Nurses feel they are no longer able to do the job the way they want to do it. Administration is responsible for the decisions about staffing levels. In some respects, this may be seen as a way of controlling staffing expenditures. Administrations of many institutions have been experimenting with various ways of doing the same or more work with less nursing staff. However, as Campbell (1994) comments,

> "Nurses' control over their practice is lost when they no longer control staffing decisions. Nurses continue to be held responsible for the outcome of their work in hospitals, while the conditions being organized there are outside their control. Working conditions may deteriorate, but demands on nurses stay high as ever" (p. 604-605).

In response to the interview question, "What can the institution do that would make your job easier or more interesting, or more challenging?", several nurses stated that they needed more staff. Cutbacks are inevitable; downsizing will continue. Nurses' concerns about staffing must be heard, so they do not feel so much at risk for personal liability, or so powerless.

In conclusion, role ambiguity is not found in nurses' discussions of role performance. At present, it is not possible to determine how much role overlap there will be between nurses and midwives. Much will depend on the midwifery pattern of practice. However, it does appear that there will be role conflict between the two professions, based in large part on the discrepancy between philosophies of birth.

Midwives have a non-interventionist approach to birth, a midwifery model. Nurses tend to have a more medical model of birth. This conclusion is supported by the literature which looked at philosophical beliefs and practice patterns. Fullerton, Hollenbach and Wingard (1996) compared the practice styles of obstetricians and certified nurse-midwives (CNM), and concluded,

> Differences were demonstrated both in beliefs about the importance of certain procedures being available and in the tendency to use these interventions. These differences manifest themselves in the way these providers care for their patients and in the different types of obstetrical care facilities in which they choose to practice. The respective educational programs for CNMs and physicians are different in their philosophies and educational goals, and emphasize different aspects of obstetrics. They are likely to produce obstetrical care providers who think differently about what things are important in the context of patient care and about approaches to delivery of care. (p. 249)

Another study compared beliefs about approaches to prenatal and intrapartum care between CNMs and physicians (Yankou, Petersen, Oakley & Mayes, 1993). There were consistent differences between the two groups in their approaches. Only one area of practice demonstrated statistically significant differences: that of teaching. However, all differences were predictable. CNMs focussed on the psychosocial, interactive, supportive type of care, whereas physicians attended to the more technical aspects of care.

Nurses in Winnipeg L&D units appear to be experiencing role stress related to poor morale, cutbacks and generally a unresponsive administration. Although this sample of nurses report they still enjoy their jobs, unrelieved stress may gradually

erode this sense of satisfaction. These nurses have generally formed their own informal support groups, and so have managed to cope. Administrators should be aware of the consequences of unrelieved job stress.

The conceptual framework, as illustrated in Figure 1, was not "proved" in some aspects. Nurses in this study did not acknowledge, through their discussion, the effects of formal education or professional standards upon their role expectations. As mentioned previously, no specific questions were asked. A new variable that impacts role expectations was discovered: a culture of L&D nursing. Other variables that were hypothesized as affecting role expectations and role performance were found to do so. These have been discussed in detail. The revised conceptual framework, based on the results of this study, is illustrated in Figure 8.

Nursing Implications

The nursing implications of this study are many, and cross many disciplinary lines, from administration to perinatal nursing, to nursing roles, to the effect of technology on nursing care. Some of the prominent nursing implications are:

- the importance of a birthing philosophy for L&D units, that is jointly created by nurses, physicians, and the consumer of the service. Follow-up must be done to assure that the goals set out in the philosophy are being accomplished.
- a need for greater collegiality in nurse-physician relationships. Both professionals have their roles, both equally important. The goal is the provision of quality care to the birthing woman. This appears to be lost at times, as the physician still maintains ultimate control over the woman and the care provided.

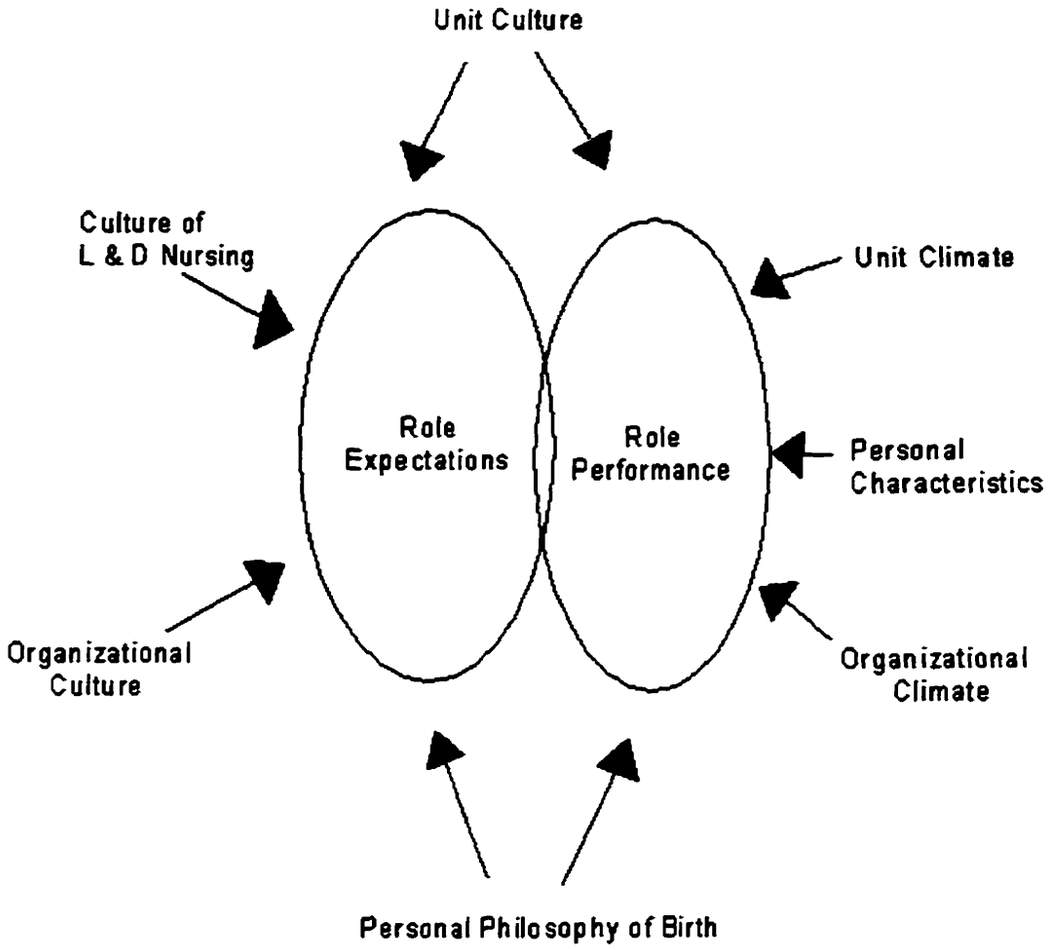


Figure 8: REVISED CONCEPTUAL FRAMEWORK

administration needs to be perceived to more responsive to nurses. Although their hands may be tied by financial realities and pressures, staff need to be more involved in the problem-solving. An attempt should be made to resolve chronic

morale problems. Nursing administration also needs to recognize the efforts of the nursing staff by random acts of kindness, and recognition of a job well done. Nurse administrators also need to also be nurse advocates, not doctor advocates, when clinical disputes arise.

- the need for recognition of the effects of technology on nursing care. Increasing rates of epidurals affect the type of care nurses provide, and the staffing ratios required.
- informal nurse support groups need to be encouraged and supported. There also needs to be recognition and support of those in distress, with the institution offering resources to assist nurses.

Many implications for research arise from this study. An important study that should be done would be to examine the roles of midwives and L&D nurses when midwifery has been established. Other research questions arising from this study are whether nurses' perceptions of the role performance are congruent with their actual role performance as well as what variables actually affect role performance. What factors and variables are involved in the decision to have an epidural? What influence does the nurse have on the decision to have an epidural? In what specific ways does nursing care differ for the woman who has an epidural, compared to the woman who has no epidural? How do nurses and physicians judge clinical credibility? How can philosophy of birth be quantified? How does medical philosophy of birth affect nursing care provided? How is, or is the nursing care in community hospitals different from tertiary care hospitals? Do patients perceive the nursing care as being different? The list of further research questions could be a long one.

To conclude, the L&D nurses in this sample of expert nurses appear to have a clear vision about their role expectations and role performance are. There are many similarities between the role expectations of nurses and midwives. Nurses described the importance of psychosocial support and assessment, as do midwives. However, nurses tend to have a more medical model of birth than do midwives. Herein lies the potential conflict. Nurses described their role performance very much like their role expectations, with much more emphasis of psychosocial/interactive aspects of care than the technical aspects of care. This finding is contradicted by other Canadian research which concluded that nurses did not listen to their patients' interpretation of the labour experience (Beaton, 1990), and were observed spending more time performing technical skills than providing psychological support and comfort measures (McNiven, Hodnett & O'Brian-Pallas, 1992). Variables affecting role expectations and role performance are comparable to what has been described in the literature. Certainly, the impact of poor morale, job uncertainty, and health care reform are evident in this study, as are the many effects of organizational and unit culture and climate. Relationships with physicians and nursing administration affect role performance daily, and can be a source of role stress.

L&D nurses in Manitoba "know" what their job is. This study has illuminated some aspects of nursing role expectations, role performance, and philosophy of birth. Now, others may also "know" the job of the L&D nurse.

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Appendix A Definition of Midwifery

A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies of midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. A midwife must be able to give the necessary supervision, care, and advice to women prior to and during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, detecting complications in the mother and child, accessing medical assistance when necessary, and carrying out emergency measures. She has an important task in health counselling and education, not only for women but also within families and community.

World Health Organization, 1992.

Appendix B

Job Descriptions of Grace Hospital, Misericordia Hospital, Victoria Hospital, Health Sciences Centre and St. Boniface Hospital.

MISERICORDIA GENERAL HOSPITAL
JOB DESCRIPTION

POSITION:	REGISTERED NURSE - GENERAL DUTY NURSING
CODE:	N
NO.:	5033
LCC:	N226 UNION: M.N.U., Local #2

ROLE:
The Registered Nurse functions as an independent self-directed professional in the delivery of direct patient care ensuring the patient is the centre of all planning and decision making activities related to care delivery. The Registered Nurse works within the framework of the Canadian Nurses Association Code of Ethics, Manitoba Association of Registered Nurses Standards and Misericordia's Core Values, philosophy, Vision, Mission, CQI Goals, policies, procedures and structures.

Establishes and is committed to interdisciplinary consultative and collaborative relationships with other members of the Health Care Team to ensure safe patient focused care. Provides leadership to other nursing staff members in the provision of care and acts as an advocate for the patient and family and the profession.

EDUCATION:
Current or pending registration with the Manitoba Association of Registered Nurses. Basic Cardiac Life Support certification is required and must be maintained according to M.G.H. established C.P.R. guidelines. Advanced preparation in relevant clinical post graduate courses may be required. Baccalaureate Degree in Nursing preferred.

EXPERIENCE:
Recent related experience may be required.

PHYSICAL:
Good physical health to meet the demands of the position.

OTHER:
Ability to work well with minimal supervision. Ability to function in stressful situations. Ability to retain information on a confidential basis.

GROWTH AND DEVELOPMENT:
Assumes professional responsibility for ongoing education and participates in professional activities for personal and professional growth.

FUNCTIONS

A. PATIENT:
Ensures all actions related to patient care are guided by Professional Standards and Ethics and are based on research.

1. Assessment of Patient Care will be by:
   (a) Obtaining an admission Nursing Data Base from the patient and family that will serve as the basis for the focus list.

   (b) Reviewing patient data obtained by the members of the health team and interpreting and identifying and preparing to meet the patients recurrent problems/needs for teaching.

2. Planning for the patient's care will be by:
   (a) Developing an individualized plan of care according to the assessment data and nursing/medical diagnosis of the patient.

   (b) Setting priorities and involving the patient and/or family as active participants in formulating a plan of care which includes realistic expectations, outcomes/goals in measurable terms and specified time limits.

   (c) Planning ongoing care and discharge requirements with the interdisciplinary team.

3. Implementation of the patient care will be by:
   (a) Provides nursing care which reflects the priorities established in planning care.

   (b) Encouraging involvement of the patient and family in the planned care and assisting the patient to make informed choices related to that plan.

   (c) Performs nursing interventions to assist the patient by increasing their knowledge and understanding of their health problems.

   (d) Communicating and obtaining feedback regarding information to/from allied personnel to ensure plan of care is implemented.

   (e) Delegating aspects of data collection and implementation of care to allied personnel in line with their job expectations.

   (f) Collaborating with members of the interdisciplinary team in the implementation of the plan of care.

4. Evaluation and documentation of the patient care will be by:
   (a) Evaluating the patients knowledge of problems, the individualized plan of care and documenting the deficits/strengths according to established focus charting principles.

(b) Evaluating the effectiveness of team members and directing effects towards positive outcomes.

B. PROFESSIONAL:

(a) Identifies the need for and participates in and applies research studies and Quality Assurance activities to their relevant area of nursing practice.

(b) Provides guidance and support to Licensed Practical Nurses and other allied nursing staff (eg. aides, porters, clerks, etc.).

(c) Serves as a professional role model.

(d) Involved as a preceptor for new staff and/or students and contributes positively to the learning experiences of students in collaboration with their teachers.

(e) Participates in related committees, teams, councils to ensure input into decisions that impact on patient care and nursing practice.

(f) Identifies unsafe care practices and assumes responsibility for effective interventions.

(g) Reports significant information to the Nursing Unit Manager.

(h) Plans and participates in relevant educational programs and inservices to increase professional skills.

C. INSTITUTION:

(a) Demonstrates awareness of and practices according to the Vision, Mission, Philosophy, Goals and Core Values.

(b) Adhere to the policies, procedures and structures of the Hospital.

D. COMMUNITY:

(a) Actively seeks opportunities for involvement on professional committees.

(b) Volunteers for health promotion/prevention activities.

(c) Acts as a professional resource to relevant community groups.

E. OTHER:

(a) Evaluates new equipment and supplies as requested.

(b) Assumes responsibility of the charge role as assigned.

5033D

(c) Performs other related duties as requested.

[d2]<L>5033

RESPONSIBLE TO: Nursing Unit Manager
RESPONSIBLE FOR:
DATE: September, 1993
SUPERSEDES: November, 1990

T. (Ted) [illegible]
Asst. [illegible] President
SEP 1993
M.G.H.
Human Resources

Post-it® Fax Note 7671	Date OCT 10	pages 1
To BILL LARSEN	From JANICE DAY	
Co./Dept. GRACE HOSP. (H.R)	Co. HEALTH SCIENCES H.R	
Phone #	Phone # 787-2623.	
Fax # 837-0545	Fax # 4895	

HEALTH SCIEN
JOB DESCR

INCUMBENT(S): **GENERIC** **DATE:** May 3, 1995

POSITION TITLE: **GENERAL DUTY NURSE (NURSE I & II)** **CLASS:** 290 **UNION:** MNU

DEPARTMENT: NURSING

SUPERVISOR'S TITLE: Unit Manager

SUPERVISORY RESPONSIBILITIES: ( ) None
Number Titles of those supervised

EDUCATION:
Graduate from an approved School of Nursing required.

SPECIAL TRAINING:
Successful completion of a relevant post-basic program maybe required, or preferred, in designated areas.

EXPERIENCE:
Recent, related, experience up to a maximum of 2 years may be required, or preferred.

PHYSICAL DEMANDS AND WORKING CONDITIONS:
Good physical and mental health. Moderate to heavy physical effort required.

LICENCES, REGISTRATIONS:
Current registration or eligibility for registration, with M.A.R.N. required.
Current B.C.L.S. certification required.

MAIN FUNCTION: (In Order of Importance):

Under the direction of the Unit Manager, the incumbent is responsible for:

- supporting, participating in and interpreting the philosophy, objectives and policies of the Health Sciences Centre, Departments of Nursing and the individual unit.

Main Function - continued

- delivering patient care in a manner which reflects professional nursing practice and for demonstrating effective comunication and teaching skills with patients and staff.

- demonstrating interest and participation in professional development activities.

ILLUSTRATIVE EXAMPLES OF ACTIVITIES OF POSITION:

The functions and responsibilities are in accordance with the M.A.R.N. Standards, but are not limited to the aforementioned functions and responsibilities:

1. NURSING PRACTICE

A) Assessment

- obtains a nursing care history from patients and/or others that serves as a basis for the development of an individual nursing care plan. Specifically the nurse:

  a) obtains critical information at initial contact
  b) reflects the perceptions of the patient and/or family of his health problem(s) and his expectations of the present hospitalization
  c) reflects the physiological condition of the patient
  d) reflects the psychosocial needs of the patient
  e) provides baseline data pertaining to activities of daily living
  f) provides information needed to begin discharge planning

- reviews patient data obtained by other members of the health team (medical history, physical examination, medical care plan, social worker's reports and community referrals)

- interprets and identifies the patients' common or recurrent problems, symptoms and behavioural changes in relation to standard nursing care plans and individual patient needs

- distinguishes between a nursing and a medical diagnosis

B) Planning

- develops a nursing care plan, using the assessment data that:

  a) sets priorities in planning care related to the most critical health problems of the individual

b) formulates a plan of care based on the nursing and medical diagnosis
c) formulates a plan of care which includes expected outcomes/goals stated in measurable terms
d) formulates a plan of care which includes expected outcomes/goals with specified time limits
e) integrates the medical plan of care
f) establishes realistic immediate and long-term outcome/goals
g) shows evidence of understanding the principles underlying nursing intervention

- involves the patient and/or family in developing the nursing care plan

- plans ongoing patient care and discharge requirements with other members of the health team

C) <u>Implementation</u>

- sets priorities with the patient and/or significant others and gives nursing care based on the patient care plan

- implements the medical care plan as delegated by the physician

- assigns aspects of care to selected members of the nursing team

- supervises care given by selected members of the nursing team

- co-ordinates the activities of the other health disciplines in implementing the individual patient care plan

- encourages active involvement by the patient in assessment, formulation of the plan of care, evaluation of outcomes and revision of the plan of care

- assists the patient to make informed choices regarding his/her responsibilities in the plan of care

- performs nursing interventions which assist the patient to increase his/her knowledge or understanding of his/her health problem(s)

- performs nursing interventions which provide the patient the opportunity to change his/her behaviour in managing his/her health problem(s)

- implements the discharge plan in co-operation with other members of the health team

D) **Evaluation**

- evaluates the effect of nursing interventions on the patient's outcomes/goals
- determines and measures the actual patient outcomes/goals
- redefines health problems in response to change in the patient's health status
- revises the plan of care to adjust to the patient's response to nursing care
- implements and evaluates the revised plan

E) **Documentation**

- records in the designated problem-oriented format:

  a) nursing history
  b) physical examination
  c) identified health problems
  d) expected outcomes/goals
  e) planned nursing interventions
  f) completed nursing interventions
  g) method of measuring actual outcomes
  h) actual outcomes

2. **TEACHING**

A) **Patient/Family**

- includes patient teaching as part of the nursing care plan
- communicates to the patient and/or family the rationale for nursing intervention
- discusses and identifies with the patient and/or family specific learning needs and how they will be met
- assesses the patient's learning readiness and uses teaching strategies to meet the patient's informational needs
- evaluates and revises the teaching strategies in relation to the patient and/or family
- communicates, to the patient, the nursing referral information that will be given to appropriate community organizations

B) Staff

- participates in teaching, guiding and evaluating the performance of auxiliary nursing personnel
- delegates aspects of the data collection and implementation of care to auxiliary nursing personnel in line with their job description
- involves auxiliary nursing personnel in formulating the patient's plan of care
- obtains feedback from auxiliary nursing personnel concerning data collection and accomplishment of delegated care
- communicates the rationale for nursing intervention to staff
- assists auxiliary nursing personnel in identifying their own learning needs

C) Students

- serves as a positive role model for professional nursing students
- contributes to the learning experiences of professional nursing students in co-operation with other Registered Nurse members of the team and the clinical instructor

3. CO-ORDINATION/COMMUNICATION

A) Patient/Family

- applies effective interviewing skills with patient and/or family
- demonstrates supportive intra/interpersonal relationships with patients or family
- uses verbal and non-verbal communication skills to identify and reduce anxiety in the patient and/or family
- identifies and reports verbal and non-verbal communication of patient and/or family

B) Staff and other Health Professionals

- communicates effectively with nursing personnel and other members of the health team

- participates in interdisciplinary patient care planning
- communicates pertinent information to provide continuity of care between shifts
- participates in nursing unit staff meetings

4. RESEARCH

- identifies need for nursing research studies
- takes part in research studies and quality assurance where appropriate
- applies research findings relevant to his/her area of nursing practice

5. PROFESSIONAL DEVELOPMENT

A) Staff

- provides data for assessment of staff's clinical performance, as appropriate
- participates in the evaluation of standards of care
- participates in the identification of unsafe patient care practices and assumes responsibility for their effective intervention and reporting of significant information relating to the incident to the Unit Manager

B) Other

- participates in evaluation of environmental safety
- participates in evaluation and revision of nursing procedures and equipment needed for patient care

C) Self

- participates in formal self-evaluation by identifying areas of strength and limitation
- seeks appropriate supervision of own actions
- plans and participates in relevant educational programs and workshops to increase professional competence and to meet personal needs and goals

- practices within the legal limitations and ethical expectations of the nursing profession

- may be required to perform other duties and functions related to this job description not exceeding above stated skills and capabilities.

CHAIRPERSON, DIRECTORS OF PATIENT SERVICES

G0794.jd

VICTORIA GENERAL HOSPITAL - JOB DESCRIPTION		
JOB TITLE: General Duty Nurse Family Birth Center		**DEPARTMENT:** Nursing Service
REPORTS TO: Nurse Manager		**APPROVED BY:** Vice President - Patient Services
ORIGINAL DATE: 04/92	**REVISION/REVIEW DATES:** 11 93;	

ALL VGH EMPLOYEES REFLECT OUR HOSPITAL'S PHILOSOPHY BY CONTINUOUSLY PROVIDING QUALITY SERVICE/CARE.

QUALIFICATIONS:

1. Current registration with the Manitoba Association of Registered Nurses required.
2. One year current Labour and Delivery experience required.
3. Midwifery preferred.
4. Bachelor of Nursing degree preferred.
5. Basic Cardiac Life Support required.
6. Performs technical procedures safely and appropriately.

RESPONSIBILITIES:

1. Demonstrate ability to provide continuous quality patient care.
2. Accept and work within the framework of the Hospital and Nursing Service Department's philosophy, objectives and policies.
3. Practice nursing based on current nursing practices which are substantiated by scientific nursing rationale using the nursing process.
4. Demonstrate excellent communication and organization skills, ensuring effective interpersonal and interdepartmental communication.
5. Is aware of and participates in his/her own professional development and assists in staff and student development.
6. Ensure annual recertification in Cardio Pulmonary Resuscitation.
7. Participate in patient and family teaching.
8. Participate in patient discharge planning in cooperation with the Primary nurse and other team members.
9. Assume the role of Primary nurse as assigned.

NOTE: This job description is representative and should not be construed as being all inclusive.

ST. BONIFACE GENERAL HOSPITAL 0594

JOB DESCRIPTION

A. JOB IDENTIFICATION

1.	JOB TITLE -	REGISTERED NURSE
2.	LABOUR CLASS # -	2350
3.	DEPARTMENT -	VARIOUS
4.	DEPARTMENT # -	VARIOUS
5.	DIVISION -	NURSING
6.	EMPLOYEES SUPERVISED -	LPNs, SUPPORT STAFF (ON OCCASION)
7.	SUPERVISOR'S TITLE -	HEAD NURSE
8.	DATE OF DESCRIPTION -	1985 DECEMBER
9.	DATE OF REVISION -	1989 SEPTEMBER 18
10.	GROUP -	MONA

B - I) JOB DESCRIPTION - SUMMARY

Under the direct supervision of the HEAD NURSE, the REGISTERED NURSE is responsible for: providing continuous, comprehensive, coordinated and patient centred nursing care to all patients; and performing other related duties as required/assigned.

B - II) DUTIES AND RESPONSIBILITIES

1. Develops and manages a comprehensive and structured nursing care plan for each assigned patient within an area of clinical specialization.
2. Prepares accurate reports of patients' condition and treatment programs.
3. Supervises the duties of the support staff (Aides, Attendants, etc.) as necessary.
4. Consults with and provides consultation to physicians, and other nursing staff.
5. Educates patients, family, staff and students within the area of specialization.
6. Participates in nursing research projects and utilizes research findings in practice.
7. Assumes responsibilities of Head Nurse, in his/her absence.
8. Participates on committees in developing organizational policies and procedures.

B - II) DUTIES AND RESPONSIBILITIES (cont'd)

9. Ensures professional and personal development in relevant areas by participating in educational programs.

10. Performs other related duties as assigned.

C. MACHINES (EQUIPMENT) OPERATED

- Blood Pressure Machine/Monitor.
- Infusion Pumps.
- Gomco.
- Stethoscope.
- Drainage tubes.
- Suctions.
- Computer terminal.

D. WORKING RELATIONSHIPS

Supervised By:	Head Nurse
Supervises:	LPNs, Support Staff (on occasions)
Other Relationships:	Nursing staff, physicians and other medical staff; personnel of related patient care services; other Hospital personnel; patients and their families.

E. QUALIFICATIONS

i. Education:

- Graduate of an approved School of Nursing.
- M.A.R.N. Registration required.

ii. Experience:

- Related clinical experience preferred.

iii. Other Attributes:

- Demonstrated leadership skills.
- Ability to retain information on a confidential basis.
- Good interpersonal communication skills.
- Ability and willingness to take initiative and assume responsibility.
- Good physical health.
- Ability to function in stressful situations.

SUPERVISOR'S SIGNATURE

HUMAN RESOURCES

VICE-PRESIDENT NURSING

POSITION DESCRIPTION

DIVISION	POSITION
NURSING	DIRECT CARE NURSE, RN/RPN
DEPARTMENT	IMMEDIATE SUPERVISOR
NURSING SERVICES	HEAD NURSE/COORDINATOR/PROGRAM MANAGER
APPROVED BY	DATE EFFECTIVE
VICE-PRESIDENT, NURSING	MAY 1995

POSITION SUMMARY:

1. Provides and co-ordinates comprehensive patient care in the assigned area, ensuring that optimal patient care is provided in accordance with:

   - the Hospital's Mission Statement.
   - current nursing scientific base.
   - the Nursing Services Department's philosophy.
   - the purpose, principal functions, and goals of the nursing units.
   - the MARN Standards of Nursing Care or the RPNAM Standards.
   - the CNA Code of Nursing Ethics.

2. Accountable to the Head Nurse or in the Head Nurse's absence, to the Charge Nurse.

3. The responsibilities of the Direct Care Nurse encompass the domains of clinical practice, communication, leadership, resource management, quality improvement, and advancement of knowledge.

QUALIFICATIONS:

1. Current registration with the Manitoba Association of Registered Nurses or with the Registered Psychiatric Nurses' Association of Manitoba.

2. A comprehensive knowledge of nursing theory and practice.

3. Demonstrated competence in clinical skills.

4. Current certification in BCLS.

5. Demonstrated effective oral and written communication and interpersonal skills.

AUTHORITY:

Authority to discharge all assigned responsibilities within established policies and procedures and approved budgets.

Authority to direct and supervise other staff members.

PROFESSIONAL RESPONSIBILITIES:

COMMUNICATION

1. Demonstrates effective communication skills and interpersonal relationships in the accomplishment of responsibilities.

2. Liaises with patient, family, and other health care providers to ensure a high level of patient care.

3. Co-ordinates interdisciplinary patient care, utilizing hospital and community resources to address patient care and family concerns.

4. Demonstrates skill in group dynamics.

5. Participates in and/or initiates need for internal/external committees, projects, continuing education activities, and staff meetings.

6. Seeks and disseminates pertinent information as appropriate, utilizing established communication systems.

7. Maintains and fosters confidentiality in all matters pertaining to the hospital, patients and their families, and staff members.

CLINICAL PRACTICE

1. Ensures provision of individualized care to assigned patients, utilizing the nursing process of assessment, planning, implementation, and evaluation.

    1.1 Collects data by interviewing, examining, observing, and utilizing reports and records.

    1.2 Demonstrates effective priorization of nursing care.

    1.3 Identifies, records, and reports to the appropriate persons significant changes in the patient's condition.

    1.4 Formulates data into a functional patient care plan considering available resources.

    1.5 Ensures implementation of the formulated plan of care.

    1.6 Demonstrates skill in performance of nursing activities in a safe and responsible manner.

    1.7 Evaluates and modifies the nursing care plan in accordance with patient assessment and response to health care interventions.

PROFESSIONAL RESPONSIBILITIES:

CLINICAL PRACTICE (continued)

1.8 Ensures physicians' orders are processed accurately and implemented.

2. Co-ordinates interdisciplinary patient care planning, utilizing hospital and community resources to address patient care and family concerns.

3. Identifies the learning needs of patients/families and ensures development and implementation of the teaching plan.

LEADERSHIP

1. Carries out professional activities in a self-directed, responsible manner which reflects legal, ethical, and practice standards.

2. Develops and utilizes effective delegation skills in patient care co-ordination.

3. Co-ordinates the activities and staff in the assigned area in a manner that ensures optimal patient care.

4. Maintains contact with peers in other settings (e.g. professional associations, other health care facilities, current literature) in order to keep abreast of practice issues and changes in the delivery of care.

5. Assumes charge nurse responsibility as appropriate, commensurate with knowledge and skill levels.

6. Contributes to a positive work environment.

RESOURCE MANAGEMENT

1. Demonstrates cost awareness in using supplies/equipment during the provision of patient care.

2. Plans care to promote efficient use of time and human resources.

3. Participates in problem-solving related to resources control.

4. May participate in interviewing and selection process of job applicants.

PROFESSIONAL RESPONSIBILITIES:

QUALITY IMPROVEMENT

1. Identifies need for QI activities, participating in ongoing evaluation and revision of work processes that will result in improved patient care.

    1.1 Ensures that patient care records are accurate, objective, behavioural, and reflect care provided.

    1.2 Identifies need for and participates in audits, surveys, pilot projects, etc.

    1.3 Ensures completion of occurrence/medication incident reports as appropriate.

    1.4 Participates in the establishment of unit-based statement of purpose, principal functions, goals, and objectives.

2. Identifies, records, and reports to the appropriate person, malfunctioning equipment, shortage of supplies, and potentially hazardous situations.

ADVANCEMENT OF KNOWLEDGE

1. Recognizes self-development as a professional expectation and actively pursues self-development and maintenance of clinical expertise.

2. Maintains current knowledge of nursing practice and developments in health care trends.

3. Fosters and facilitates student and collegial learning.

4. Identifies and communicates to the Head Nurse potential areas for nursing research.

5. Utilizes research findings in nursing practice.

6. Participates in performance review process, based upon position description, recognizing the value of self-appraisal and personal goal setting in accordance with current professional and contractual guidelines.

Performs/delegates other related activities in a responsible manner.

Appendix C Invitation to Participate: Nurse Manager/Head Nurse

As a Nurse Manager/Head Nurse in an institutionthat provides obstetrical services, you are invited to participate in a study that seeks to describe what the labour and delivery nurse is expected to do (role expectations), what she/he actually does (role performance), what factors she/he sees as affecting her/his ability to do the job, and the nurse's personal philosophy about the birth process. The knowledge gained will assist in describing the role of the L&D nurse, and will assist with the comparison of this nursing role to that of other health care providers.

This research study is being done by Margaret Quance, R.N., B. N., who is a graduate student, Faculty of Nursing, University of Manitoba. This study is being done under the guidance of Dr. Annette Gupton, Ph. D., Dr. Janet Beaton, Ph.D., and Dr. Jeff Sisler, M.D. The results of the study will be presented as a Master's Thesis.

You are toidentify three to five nurses who demonstrate superior knowledge and skills in providing care to labouring women (See Guidelines for Selection of Nurses). You would then give each selected nurse an Invitation to Participate. The selected nurses would then contact the researcher , and in so doing, would express an interest in participating in the study.Each nurse will be interviewed for one to one and one half hours, at her/his convenience in a setting of her/his choice.

You, as a Nurse Manager/Head Nurse will be asked to provide information about the organizational culture and climate that may have an effect on the role expectations and role performance of the nurse who works in the institution (See Institutional Data Collection Form). The institution will not be identified by name in the data, but by code known only to the researcher. This data will be mailed to the researcher in a self addressed stanped envelope.

This study will be presented to the Ethical Review Committee, Faculty of Nursing, University of Manitoba, April 4, 1996.

Should you have any questions, please feel free to contact Margaret Quance at 837-0223 (work) or 832-4104 (home), or Dr. Annette Gupton at 474-6220.

Thank you for your consideration.

Margaret Quance, R.N., B.N.

Appendix D Guidelines for Selection of Nurses

You are asked to identify from three to five nurses who presently work on the labour and delivery/birthing unit, who, in your opinion, have superior knowledge and skills in caring for labouring women. These nurses may be consistently highly thought of by their colleagues and their patients. If your sister or daughter were to have a baby, you would want this nurse to care for your family member.

The nurses you identify must also:

-have at least three years of full time experience in a labour and delivery/birthing unit. (These years of experience do not need to have been at your institution).

-be a R.N. or B.N.

-must **not** have had any midwifery background or education.

Please provide each of the selected nurses an Invitation to Participate. It then will be the choice of each selected nurse to contact the researcher, and so doing, indicate an interest to participate.

Thank you for your assistance.

Appendix E Invitation to Participate: Staff Nurse

Dear _____,

You have been identified by your supervisor as having superior knowledge and skills in caring for labouring women. Because of your expertise, your opinions and perceptions of your job as a labour and delivery nurse are greatly valued. You are invited to participate in a study that seeks to describe what the labour and delivery nurse is expected to do, what she/he actually does, what factors affect her/his ability to do the job, and your own philosophy regarding the birth process. The knowledge gained will assist with the comparison of the role of the labour and delivery nurse with the roles of other health care providers.

This research study is being conducted by Margaret Quance, R.N., B.N., as a part of her course requirements for a Master's in Nursing degree at the University of Manitoba. This study is being done under the guidance of Dr. Annette Gupton, Ph. D., Dr. Janet Beaton, Ph. D., and Dr. Jeff Sisler, M.D. The collected data will be shared with this thesis committee. The results will be based on group data, not individual responses. No one will ever know how you, as an individual, responded.

Your participation involves volunteering 1 to 1 1/2 hours of your time, to be arranged at your convenience, in order to be interviewed. Some very general questions will be asked, but mostly you will be asked to talk about your work and your feelings about the birth process. The interview will be taped, and the tape transcribed. Demographic data will be collected as well. Your identity will remain anonymous and data confidential. The tape and transcribed interview data will be stored in a locked filing cabinet in the researcher's home, and will be destroyed at the completion of the project. This data will not be shared with anyone from your institution.

If you wish to participate in this study, please contact Margaret Quance, at the telephone numbers below.

You are free not to participate in this project. You may also withdraw from the project at any time, without penalty. If you have any questions about the project, please contact Margaret Quance at 832-4104 (home) or 837-0223 (work), or Dr. Annette Gupton, at 474-6220.

Thank you for your consideration.

Margaret Quance, R.N., B.N.

Appendix F Consent to Participate

I give my consent to participate in a study exploring the perceptions of labour and delivery nurses about what the expectations of the job are, what the job is really like, factors affecting the ability to do the job, and my philosophy about the birth process. I understand that I will be interviewed for one to one and one half hours and that this interview will be transcribed at a later time. The knowledge gained will assist with the understanding of this specialty nursing role, and assist with the comparison of nursing and other health care provider roles.

I have received a written explanation of the project. I realize that I will be interviewed for one to one and one half hours, and the interview will be taped and transcribed. Demographic data will be collected at the time of interview. I understand that my participation is voluntary and that I may withdraw at any time. I have been reassured that my identity will not be revealed. If I wish, I will receive a copy of the results of the research data. Any questions I have had, have been answered to my satisfaction.

I realize that the data will be shared with the thesis committee, comprising of the researcher, Dr. Annette Gupton, Dr. Janet Beaton, and Dr. Jeff Sisler. I realize that the results will be based on group data, not individual responses.

This project has received ethical approval from the Ethical Review Committee, Faculty of Nursing, University of Manitoba. The data will be stored securely, until the completion of the project, when it will be destroyed. If I have any further questions about the study or my participation, I can contact Margaret Quance at 832-4104, or Dr. Annette Gupton at 474-6220.

My signature indicates that I am informed, and I agree to participate as a volunteer subject.

Date_____ Signature_____

Date_____ Signature_____

Margaret Quance, R.N., B.N.

Appendix G Participant Demographics

Interview # _____

Age: _____years

Basic Nursing Education: LPN_____ RN_____ BN_____

Highest Education Attained: RN_____ BN_____ MN_____ PhD_____

Years of nursing experience since graduation from basic program _____ years.

Years of Labour and Delivery Experience _____years.

Your first position in Labour and Delivery was in a: rural hospital _____

community hospital _____

tertiary hospital _____

Your present position is in a: community hospital _____

tertiary hospital _____

You have held your present position in Labour and Delivery for _____ years.

You have been employed at your present institution for _____ years.

Appendix H Institution Data Collection Form

The organizational culture of an institution has an effect on the role expectations of the nurse who works there. The organizational culture may be composed of several elements, some of which may be the acuity of the hospital, whether medical residents are present, the proportion of high versus low risk women, intervention rates, and the formal orientation that is offered nurses. Please complete the following questions:

1. Your institution is considered: a) secondary care _____

   b) tertiary care _____

2. Your institution has, on site, 24 hours a day:

   a) obstetrical residents yes_____ no_____

   b) family practice residents yes_____ no_____

   c) obstetrical and family practice residents yes_____ no_____

3. For the year 1994-1995, please indicate:

   a) percentage of patients admitted under obstetricians _____%

   b) Percentage of patients admitted under family practice physicians _____%

4. For the year 1994-1995, please indicate the number of deliveries that took place at your institution. _____ deliveries

5. For the year 1994-1995, please indicate the percentage of women who had risk scores of 5 and under. _____%

For the year 1994-1995, please indicate the intervention rates for women on your obstetrical unit. The method of calculation is shown.

6. Caesarean Section rate _____% $\frac{\text{\# emergency C/S}}{\text{\# vaginal deliveries + \# emergency C/S}}$

7. Epidural rate _____% $\frac{\text{\# epidurals}}{\text{\# vaginal deliveries + \# emergency C/S}}$

8. Operative delivery rate _____% $\frac{\text{\# forceps deliveries + \# vacuum extractions}}{\text{\# vaginal deliveries}}$

9. Syntocinon use rate _____% $\frac{\text{\# inductions + \# augmentations}}{\text{\# vaginal deliveries + \# emergency C/S}}$

Please indicate the formal orientation process that an experienced labour and delivery nurse, new to your institution, would experience.

10. _____hours for formal orientation to the institution (not the unit).

11. _____hours of classroom time, specifically related to the L&D unit.

12. _____hours of clinical orientation to the L&D unit (buddied with the clinical teacher).

13. _____hours of clinical orientation to the L&D unit (buddied with another nurse).

14. _____hours of another form of orientation. Please specify what form this is:

_____

_____

_____

15. Does your unit presently have/utilize a philosophy of birth? yes_____ no_____

16. If yes, please enclose a copy.

Appendix I Interview Guide

Tell me about the type of nurse you would consider best suited to work in L&D.

Describe the characteristics the ideal L&D nurse would have.

Tell me about the best nurse you ever knew who worked in L&D.

How does the ideal L&D nurse interact with the patients? With the doctors? With other nurses?

What does the ideal nurse believe about the process of birth?

How does the ideal nurse resolve or deal with situations of conflict between patients and doctors? Between other nurses and patients?

What is the best thing about being a L&D nurse?

What is the worst thing about being a L&D nurse?

How does your job differ from what you would like it to be, to what is really like ?

If you could change anything about your job, what would it be?

How would you describe your working relationship with the doctors at your place of work?

Would you describe your relationship with doctors as a collegial one?

Do you feel that the doctors listen to your opinions and feelings?

Do you feel your nursing colleagues support each other in stressful situations?

Describe an ordinary day at work for me.

What could the institution do that would make your job more interesting? Easier? More rewarding?

Describe the response you have received when you gave an opinion about how to improve the job/the unit.

Describe the way you interact with patients and their families.

Describe a situation when your nurse manager/head nurse supported a patient care decision you made.

Describe a situation when you found yourself in conflict about a decision a patient and her family had made.

Describe a situation in which you found yourself in conflict about a decision a physician had made.

Describe the ideal labour.

Describe your philosophy about the birth process.