Certified Nurse-Midwifery Care of the Postpartum Client: A Descriptive Study

by

Melanie Kohl

Ann Morten

Prairie O'Mahoney

Catherine Pelosi

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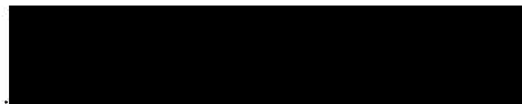
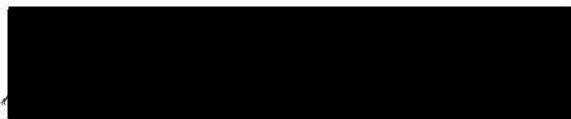
Approved:

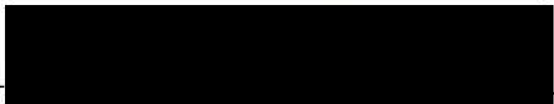
Carol Howe, RN, DNSc, CNM, Professor, Research Advisor



Nancy Sullivan, RN, MS, CNM, First Reader



Marie Scott Brown, RN, PhD, PNP, Second Reader



Carol Lindeman, RN, PhD, FAAN, Dean, School of Nursing

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TABLE OF CONTENTS

CHAPTER		PAGE
I	INTRODUCTION	1
	REVIEW OF THE LITERATURE	3
	Process of Nurse-Midwifery Care	4
	Content of Nurse-Midwifery Care	19
	CONCEPTUAL FRAMEWORK	33
II	METHODS	37
	DESIGN	37
	SAMPLE	37
	DATA COLLECTION	39
	PROTECTION OF HUMAN RIGHTS	41
	DATA ANALYSIS	41
III	RESULTS	45
	SAMPLE	45
	CONTENT COMPONENTS	50
	Aspects of Nurse-Midwifery Care	50
	Physical Examination	59
	Parent Education	59
	Topics Discussed	60
	Summary of Content Components	66
	PROCESS COMPONENTS	66
	Process	66
	Initiation of Subjects	69
	Emotional Tone of Visit	70

CHAPTER PAGE

General Order of Visit 70

Evaluator's Subjective Reaction . 71

ADDITIONAL FINDINGS 73

Broadening of Categories 73

New Findings 75

IV DISCUSSION 82

CONTENT COMPONENTS 82

PROCESS COMPONENTS 86

V CONCLUSIONS 94

STUDY SUMMARY 94

LIMITATIONS 96

IMPLICATIONS FOR PRACTICE 98

RECOMMENDATIONS FOR RESEARCH 98

REFERENCES 101

APPENDICES

ABSTRACT

LIST OF FIGURES

FIGURE

1 The With-Woman Model of Nurse-Midwife/Client Interaction: A Process Component of Care 95

LIST OF TABLES

TABLE		PAGE
1	Components of CNM Care as Defined by Lehrman	9
2	Demographic Characteristics of the Client Sample	46
3	Demographic Characteristics of the CNM Sample	47
4	Analysis of Aspects of CNM Practice Content Categories Identified in Five Postpartum Visits.	50
5	Analysis by Content Categories of Topics Discussed in Five Postpartum Visits . . .	61
6	Analysis of Process Components in Five Postpartum Visits	73
7	Definitions of New Codes Identified in Ananlysis of Five Postpartum Visits . .	84
8	Frequency of Occurrence of Codes Which Were Collapsed into Major Concepts From Five Postpartum Visits	85

APPENDICES

APPENDIX

A Components of Prenatal Care Measurement Instrument

B Aspects of Nurse-Midwifery Care: Conceptual and Operational Definitions

C CNM Questionnaire

D Client Questionnaire

E CNM Informed Consent

F Client Informed Consent

G Chart Review Form

H Components of Postpartum Care Measurement Instrument

CHAPTER I

Certified nurse-midwives (CNM) have been providing maternity care in the United States since 1925, professing a philosophy of family-centered care with minimal intervention in normal processes. Reviews of the literature which explore the quality of nurse-midwifery care describe that care as safe, acceptable, and accessible (Diers & Burst, 1983; Meglen & Burst, 1974). The standards of the profession have been clearly stated by the American College of Nurse Midwives (ACNM, 1982; 1985). However, the components of nurse-midwifery care that differentiate it from standard medical care are less clear. Although CNMs have traditionally claimed that their care was different than physician care, they have had difficulty articulating those differences. Midwifery research has focused on the content and outcome of CNM care with particular interest in the prenatal and intrapartum periods. There is little in the literature on the content of CNM care in the postpartum period and virtually none describing the process of CNM care in general, despite the obvious need for professional definition of care.

An understanding of the process as well as content of care is an essential component in the development of a theoretical foundation for CNM practice. Identification of the components of CNM care can generate data for further understanding the effectiveness and utilization of nurse-midwives.

Lehrman (1981) designed and conducted a descriptive study which identified the components of care provided by CNMs during the prenatal period. Her study included the development of a measurement instrument identifying the components of care which provided a format for examination of those components in terms of content and process. This study served as preliminary exploration for more comprehensive research currently being conducted (Lehrman, 1987) contributing to the establishment of a theory-based nurse-midwifery practice model.

In discussing the proposed practice model, Lehrman stated that the area of postpartum care has not been explored. The purpose of this study was to describe postpartum care delivered by CNMs in the context of Lehrman's framework for components of nurse-midwifery care.

REVIEW OF LITERATURE

Weaknesses in CNM literature which attempt to define and study the content and process of nurse-midwifery care are similar to weaknesses associated with nurse practitioner research in general. These weaknesses are directly related to the early politics of nurses functioning in an expanded role as temporary care providers to fill the shortage of physicians. Defining the problem solely as one of access to care assumed that physician services were adequate in every respect except quantity. Thus, although later developments have highlighted nursing's unique contributions, the primary criteria for evaluation of nurse practitioners' abilities have focused on the ability to provide traditional medical services (Diers & Molde, 1979). As a result of this political design, research on nurses practicing in expanded roles has been forced to focus on the justification within the medical framework of health care. The unique process and content of their practice has only recently emerged in the professional literature.

The review of the literature has been divided into two sections, the process of CNM care and the content (physiologic and psychologic) of postpartum care as provided by CNMs. Because this is research related

specifically to the postpartum care provided by certified nurse-midwives, the literature reviewed has been limited primarily to publications by CNMs.

Process of Nurse-Midwifery Care

Nurse midwifery practice has been characterized as care which emphasizes the normal aspects of childbearing in a low-intervention mode. In addition, the CNM's commitment to patient participation in decision-making and individualized management plans is indicative of the profession's philosophical approach to care. Nurse-midwifery research which has attempted to describe and/or measure the process of CNM care has frequently confused philosophical values and the interventions associated with them with a precise conceptual definition of the process of that care.

Lehrman's (1981) research is the only study discovered in the literature which has truly examined the process as well as content of nurse-midwifery care. Because this research project has depended so heavily on the measurement tool used in Lehrman's work, her study has been described in some detail.

Lehrman's work was a qualitative study designed to identify and describe the components of prenatal care as provided by nurse-midwives. The data collection method chosen by Lehrman was audio-taping of client

visits, as opposed to participant observation or video taping. The latter options were rejected due to prohibitive cost, technical difficulties and probable reduction in sample size. The report included a pilot study conducted to develop an instrument that would adequately identify and measure the components of prenatal care.

Initial categories of CNM care were developed based on a review of articles written by nurse-midwives over a 25 year period. Three prenatal visits were tape-recorded. Lehrman analyzed these using a grounded theory approach for further development of categories. The measurement instrument that evolved from this pilot study was reviewed by three practicing CNMs in an attempt to ensure its content validity.

The instrument was designed to facilitate content analysis of subsequent audio-recorded interviews between nurse-midwives and their prenatal clients. Components of prenatal care were divided into areas of content and process and the instrument was structured to identify the frequency and duration with which each component occurred during the course of a visit. The content components of a prenatal visit were identified as the physical exam, services provided, and the topics discussed. Process components were defined as the

attitudes and approaches to care assumed by the CNM or the methods used to provide care. These abstract definitions of process were further described as the amount and type of conversation between midwife and client, the emotional tone of the visit evidenced by incidents of laughter, crying, and/or reassurance, and, the general order of the exam. The tool, as developed by Lehrman, is included as Appendix A.

Lehrman's pilot study also presented conceptual and operational definitions for eight concepts thought to be essential aspects of nurse-midwifery practice. These were identified as: (a) continuity of care, (b) family-centered care, (c) education and counseling (d) noninterventionist care, (e) flexibility in care, (f) client participation in care, (g) consumer advocacy. and (h) quality and amount of time spent during each visit (Appendix B). These aspects of nurse-midwifery management were characterized as content components and were quantified on the measurement tool as to frequency and duration of occurrence. It might be argued that these aspects of care could have been defined as process components because they are representative of attitudes assumed by the practitioner. Lehrman, however, suggested through operational definitions that these attitudes philosophically directed the services

provided to the client and were thus consistent with the conceptualization of content as care provided.

In the second phase of her study, Lehrman analyzed the content of a total of 40 audio-recorded interviews between 23 nurse-midwives and their prenatal clients. The study sample for the second phase was chosen from the membership roster of Region VI of the American College of Nurse-Midwives (ACNM). All members of the region were invited to participate and a convenience sample was selected from those who agreed to participate. There were three selection criteria for the CNMs: (1) experience of more than one year of practice, (2) practice in a facility that provided prenatal care, and (3) willingness to record a prenatal visit, complete consent forms and supply demographic information. The criteria for the clients were nulliparity and willingness to complete consent and demographic information forms.

Lehrman's data analysis was based on measurement in minutes duration or frequency of occurrence of each item on her tool. She reported that with the exception of the physical exam, not all components appeared consistently in all visits. The one topic of discussion (content category) which occurred in all of the visits was pregnancy progress and interim history.

The client's health status and preparation for labor were frequently highlighted in discussion.

The general order of the visit was categorized by Lehrman as a process component of care which suggests that she perceived that the format of the visit reflected a general approach to care provided. Her data analysis revealed that in 75% of the visits, the physical exam occurred between two distinct periods of conversation between client and midwife. The categories for general order of the visit are listed in her measurement tool (Appendix A). Lehrman also reported that there was conversation between client and CNM 100% of the time with the CNM talking more than the client in 87.5% of the visits. The client's significant other was present and participated in 32.5% of the visits.

Other process components measured by Lehrman included: (a) the presence of social conversation between client and CNM as initiated by CNM (67.5%) or as initiated by client (37.5%), (b) topics introduced by CNM (100%) or by client (97.5%), (c) incidents of laughter (100%) and reassurance (100)%, and (d) questions asked by CNM (100%) or asked by client (97.5%) (See Table 1). The percentages represent in what portion of the total visits analyzed these

Table 1

Components of CNM Care as Defined by Lehrman (1981)

Content*	Process*
Aspects of Nurse-Midwifery Practice	Talking by CNM, Client, Significant Other (S.O.)
Physical Exam	Questions Initiated by CNM, Client, S.O.
Client participation in Childbirth Education	Social Conversation
Topics Discussed	Silence
Health Status	Initiation of Subjects
Preventive Health	Emotional Tone of Visit
Treatments	General Order of Visit
Labor Preparation	
Preparation for Parenthood	

components were present. Lehrman suggested that the frequency with which these process components were identified indicated a supportive, relaxed, warm relationship and rapport between the client and the nurse-midwife. The existence of a relationship of this nature was implied to be a primary factor in the distinctive process of CNM care.

Coded data from the measurement tool and demographic questionnaires were submitted for computer analysis to determine correlation both among the individual components themselves and between these components and the demographic characteristics of the clients. For example, the amount of time taken for discussions of labor preparation was found to be related to the amount of time taken for participative care ($r=0.70$). Also, the length of the visit and the amount of talking by the client was found to increase directly with the client's age. Analysis of the data failed to reveal any new categories that had not been previously identified during the process of tool development, adding content validity to the tool.

The findings of the study indicated that in general, prenatal visits with participating nurse-midwives lasted longer than visits to other care providers as reported in the literature (Ryan &

Osborne, 1976; Zuckerman, Starfield, Hochretter, & Kovasnay, 1975; Hill, Winston, & Campbell, 1973), with the nurse-midwives averaging 23.7 minutes and physician averages ranging from 6 to 13 minutes. Lehrman stated that her analysis suggested that the content of the visits with CNMs appeared to reflect the identified needs of the individual client.

Generalizability of Lehrman's study to a larger population of CNMs can be viewed as limited due to her use of a self-selected, convenience sample of nurse-midwives. There is a strong probability that the research instrument developed reflects the investigator's philosophy of prenatal care and may measure inclusively or exclusively to that philosophy.

The client sample was primarily white and married with moderate incomes and the setting in which clients received their care was primarily metropolitan. The potential influence of the demographic variables on the findings is especially important when looking at the CNM philosophy of client-directed care. Lehrman, however, did not refer to this in her discussion of the results, possibly further limiting the generalizability of her findings to other populations.

Despite these limitations, Lehrman's research initially identified components of care which could be

incorporated into a theory-based practice model for nurse-midwifery care. Her inclusion of conceptual and operational definitions of content and process of care is unique. Other authors have identified and/or studied similar concepts but without the precision of definition. A review of some of these related works follows.

Diers (1981) reviewed the findings of three separate, retrospective studies conducted by graduate students from Yale University in an attempt to describe the structure, process, and outcome of CNM care during the prenatal and intrapartum periods. The intent of this review was to describe nurse-midwifery care as unique and to support the notion that CNMs are not simply a different agent of care but deliver a separate and effective form of care as well. The studies reviewed by Diers were limited by retrospective design, sampling procedures, and use of patient charts as primary data sources. The data generated support that even in high risk populations, CNM care can be shown to produce outcomes not only equal to those produced by more traditional care, but in many cases significantly better. These conclusions concurred with a multitude of previous outcome studies of CNM care (Bennets, 1981; Bennets & Lubic, 1982; Browne & Issacs, 1976; Corbett &

Burst, 1983; Diers & Burst, 1983; Dillon, Brennan, Dwyer, Risk, Sear, Dawson, & van de Wielle, 1978; Doyle & Widham, 1979; Ernst & Gordon, 1979; Mann, 1980; Meglen & Burst, 1974; Reinke, 1982; Ross, 1981; Schorfheide, 1982; Scupholme, McLeod, & Robertson, 1986; Thompson, 1986).

Diers (1981) stated in her publication that "measures of the process of nurse-midwifery care document low-intervention personalized care" (p. 85). Process, however, was never conceptually defined. Close inspection of these studies revealed that therapies, be they traditional medical or more non-interventionistic, were measured, but that the nature of the care was not described or measured. By Lehrman's (1981) definitions, it must be determined that the content of care was examined in these studies, but the process was not. According to Lehrman, interventions would be seen as services provided, and thus a content component of care, whereas the approaches and attitudes assumed by the CNM would more correctly be defined as process.

Beal (1984) conducted a retrospective study in an attempt to describe the process of nurse-midwifery intrapartum care. Charts of 85 women admitted to the hospital in labor at term were reviewed to identify

differences between nurse-midwifery and medical intrapartum management. "Process" criteria included administration of intravenous fluids, use of amniotomy, electronic fetal monitoring, administration of pain medications and anesthesia, mode of delivery and incidence of episiotomy/laceration. The results of the study supported the idea that CNMs give patient care involving more selective use of technology resulting in a greater number of spontaneous deliveries. The criteria employed in the study, however, were items of content, i.e., Lehrman's non-interventionist aspect of CNM care. It appears that this study, like others, more effectively describes the content of CNM care rather than the process of that care.

Thompson (1981) conducted a study to determine the relationship between specific components of a prenatal care process directed by nurse-midwives and the health behaviors of primigravidas, their knowledge about pregnancy and their reported satisfaction with care and the caregiver. Thompson conceptually defined process as "the way prenatal care is given" (p.29). The lack of an operational definition in this study, however, limited the understanding of this concept.

The study involved 108 primigravidas who were randomly assigned to one of four study groups at the

time they registered for prenatal care. Subjects were followed until 32 weeks gestation, at which time 68 women remained in the study. The experimental treatment was a specially designed prenatal care process applied to Groups One and Two. Subjects assigned to both Groups One and Two had prenatal care provided by one of two CNMs who had been trained by the researcher in the experimental process. Thus, the only distinction between these two groups was the individual caregiver. Thompson used this design as an attempt to minimize the possible effects of an individual caregiver's personality on the study results. Group Three had standard midwifery care and continuity of caregiver without the special treatment. Group Four had neither continuity of caregiver nor special treatment.

The experimental treatment incorporated a behavioral approach to care and involved training the CNMs in identifying behavior needs. Thompson's published report, however, did not include a description of this training nor did she define "traditional midwifery care". The behavioral approach included a motivation program for clients which consisted of an appointment system as well as a written medication and referral card system to be carried by

clients as reminders. Involvement of the client in decision-making was also included in the treatment protocol.

A structured interview format was used for baseline data collection from eligible participants. The interview included reasons for seeking prenatal care, desirability of the pregnancy, prepregnant health behaviors, support person(s), and preferences for prenatal care. A health knowledge pretest was also administered. Each participant was again interviewed at 32 weeks gestation using a structured format to establish reported compliance behaviors, pregnancy health behaviors at that time, evaluation of care received, and satisfaction with the caregiver and care. A final chart review was done to obtain verification of reported patient compliance with prenatal visits, medications, lab tests, and referrals completed.

Thompson developed four measures of outcome for her study: (a) a pregnancy health behavior score, (b) a knowledge score, (c) a satisfaction with caregiver score, and (d) a satisfaction with care score. Although Thompson states that the tools developed to obtain outcome scores were tested, scores for validity and reliability were not reported. Data from the study failed to demonstrate a relationship between the

components of the experimental prenatal process of care and the outcome criteria.

Despite a commendable use of outcome criteria closely related to the effectiveness of nursing or nurse practitioner care, there are several weaknesses of Thompson's study which limit its usefulness in defining the CNM process of care. First is the lack of clear conceptual and operational definitions of the process of care. Information regarding the content of the experimental treatment is limited and more information regarding the selection, training and observation of the experimental nurse-midwives would be necessary to more accurately assess this study's value in identifying the "process" of CNM care. Finally, the inability to establish a significant relationship between the independent and dependent variables may well be related to the small sample size which directly limits the probability of obtaining a significant result.

With the exception of Lehrman's study, the literature reviewed was found to be weak in terms of description and measurement of nurse-midwifery process. It does, however, lend support to Lehrman's description of the eight aspects of CNM care listed previously. These aspects of CNM care, defined as content

components by Lehrman, have been alluded to by other authors as well.

Erwin & Hosford (1987) in a description of the nurse-midwifery management process addressed the importance of getting to know one's client, inviting the client to take part in her own health care (participative care), and problem-solving with the client to find the most appropriate plan of care (flexibility). Carveth (1987) in a scholarly defense of conceptual models for nurse-midwifery practice speaks of mutual collaboration (participative care) between care-giver and client, a concrete demonstration of the philosophical concept of care as a balance of the art and science of practice. The incorporation of counseling, teaching and advocacy, all aspects of CNM care as defined by Lehrman, into CNM practice has been described by Carveth as a natural growth from the very roots of the nursing profession.

<u>Summary</u>

This segment of the literature review has demonstrated that the process of CNM care has neither been consistently and clearly defined nor even studied. In response to the paucity of process related studies, a number of authors have recently challenged researchers within the nurse-midwifery community to

undertake studies which will identify the process of CNM care.

Beal (1984) noted that the availability of nurse-midwifery care to all child-bearing women is dependent, in part, on the ability of CNMs to define for themselves and for others the nature of their practice. Carveth (1987) noted that conceptual models developed from content and process studies would help to organize the beliefs and knowledge about the professional roles and practice of CNMs into a sound, definitive framework.

Content of Care

A diligent search of nurse-midwifery literature on postpartum care yielded little in the way of independent research conducted by CNMs. The main emphasis in maternity research has been prenatal care and its related outcomes which are relatively distinct and easy to measure. The successful physiologic and psychologic transitions from pregnancy to parenthood are gradual processes that have no distinct endpoints and are inherently difficult to measure. It may be due to this that prenatal care has been studied extensively while postnatal care has not.

The existing literature reviewed did yield three broad categories related to CNM care of the postpartum

client and her family. These categories have been classified here as maternal issues, infant/parenting issues, and marital/family relationship issues.

Maternal Issues

Maternal issues include both physiologic and psychosocial tasks. Physically the woman must make the transition from pregnant to non-pregnant, either inhibiting or promoting lactation. Emotionally she must make the transition from a state of child-bearing to child-rearing and possibly from mate to mate-mother.

Physiological Literature.

According to the core competencies for CNMs set by the American College of Nurse-Midwives (ACNM), the CNM may assume responsibility for the management of both the client and her neonate during the postpartum period, using the nurse-midwifery management process (ACNM, 1985; Erwin & Hosford, 1987). Inherent in the CNM's responsibility is a thorough understanding of the anatomic and physiologic processes normally involved in the puerperium, which serves as a guide to the identification of and treatment or referral of any deviations from those norms. The literature composing the theoretical foundations for this knowledge can be found in a review of Varney (1987), a comprehensive

text for nurse-midwifery care, or in any general obstetrical text.

The changes of the puerperium typically include the normalization of vital signs, hormonal changes, involution of the uterus and other organs, healing of the genitalia, return of bladder and bowel function, breast changes and lactation, and weight loss. Other areas of concern are nutrition, exercise, rest, family planning, screening for breast and cervical cancer, administration of Rhogam when appropriate, and sexual concerns that are of a physical nature (Hames, 1980; McKenzie, Canaday, & Carroll, 1982; Varney, 1987).

The only two pieces of actual research by CNMs located were a small experimental study of the management of postpartum breast engorgement in nonbreastfeeding women (Meserve, 1982) and an exploratory descriptive study of postpartum weight loss (Olsen & Mundt, 1986). Other CNM literature related to postpartum care included reviews of previous research from other disciplines or descriptive accounts of clinical content (Davidson, 1974; Ezrati & Gordon, 1979; Jennings & Edmundson, 1980; McKenzie, et al., 1982).

The standard nurse-midwifery text in this country identifies a management plan for the physiologic

aspects of the puerperium, including changes experienced by postpartum women, assessment and treatment of complications, relief of postpartal discomforts, and anticipatory guidance and instruction for client and family (Varney, 1987). The most critical time for physiologic assessment is in the immediate postpartum period, with descriptions of the content of this care also being found in general nursing and medical textbooks (Olds & Ladewig, 1984; Reeder, Mastroianni, & Martin, 1983). But continued surveillance is facilitative of the client's successful passage through the postpartum period (Jennings & Edmundson, 1980; Varney, 1987). This continuity is professed to be an integral part of CNM philosophy (ACNM, 1985).

It becomes clear when reviewing the CNM literature that the contributing authors have a nursing perspective - that of awareness on the care provider's part of the client's responses. There also appears to be a philosophical emphasis not found in the literature from other disciplines. Examples of this are the supportive corroboration with women in their choices whenever possible (Doyle & Widhalm, 1979), facilitation of women's understanding and acceptance of the physiologic changes their bodies are undergoing

(Jennings & Edmundson, 1980; Varney, 1987), encouragement of self-care with anticipatory guidance (Doyle & Widhalm, 1979; Jennings & Edmundson, 1980), and assistance with breast feeding (Varney, 1987).

Psychosocial Literature.

Psychosocial tasks in the puerperium include incorporation of the birth experience and maternal role adaptation. The birth of an infant initiates a complex process which ideally leads to the establishment of a satisfying relationship between the woman and her infant. Some of the factors which have been identified as having a significant impact on this process include the woman's personal experience of being mothered, her perception of nurturing care during the childbirth process, the congruence of her birthing experience with her expectations, the congruence of her new baby with the 'ideal' baby she imagined during pregnancy (McKenzie, et al., 1982), her own level of maturity, previous childbirth experiences, and adequate support systems (Graef, McGhee, Rozycki, Fescina-Jones, Clark, Thompson, & Brooten, 1988). In addition, concerns the mother may have about herself, her infant, and her family have the potential to affect adaptation to the mothering role if they interfere with her ability to

cope with the stresses of the puerperium (Graef, et al., 1988; Varney, 1987).

Maternal role adaptation may include a grief reaction in response to a perceived loss. The losses that a woman may experience can range from the relatively abstract, such as loss of prestige associated with pregnancy or loss of the 'ideal' baby (McKenzie, et al,, 1982), to the very concrete loss of the child through stillbirth, abortion, miscarriage, or adoption (Varney, 1987).

The experience of perceived loss coupled with the physiological stressors of the immediate postpartum period may lead to postpartum blues (Hazle, 1982; Varney, 1987). Symptoms of a mild depression such as emotional lability, poor concentration, irritability and anxiety are characteristic of the blues. They are most commonly seen in the first week of the puerperium, and are self-limited (Hazle, 1982; Varney, 1987). Postpartum depression is a more serious disturbance, lasting significantly longer than the blues and often requiring professional intervention to resolve (Hazle, 1982).

Women have an almost universal need to recount in detail the birth experience (Affonso, 1977; Hazle, 1982; Jennings & Edmunson, 1980; McKenzie, et al.,

1982; Stolte, 1986; Sullivan, & Beeman, 1981). This process is an important part of the assimilation of the birth experience (Mckenzie, et al., 1982; Sullivan & Beeman, 1981).

As mentioned previously, additional factors which can effect maternal adaptation are unresolved concerns regarding maternal health, the baby, or the family. Graef et al. (1988), motivated by research which indicated a correlation between support and continuance of breastfeeding, investigated the postpartum concerns of 32 breastfeeding mothers through the first postpartum month. They found that 97% of these women reported concerns about their infant, 81% reported concerns about themselves, and 19% reported concerns about family and friends. The most commonly cited concerns about infants were feeding concerns (80%), followed by behavioral concerns (55%), and physical concerns (48%). Maternal concerns about the physical aspects of the puerperium were more frequently cited than emotional concerns (81% versus 69%), with the most frequently cited concerns related to breast and nipple discomfort. Feeling a lack of support from her coparent and her family was reported by four women (17% of 32 participants) in the first postpartum week and by two additional women (19%) in the second postpartum week.

In the third and fourth postpartum weeks, however, none of the women in the study expressed concerns about co-parent or family support.

One potentially confounding variable in this study was the fact that seven of the participants were enlisted from the midwifery service with the remainder enlisted from a tertiary care center. It was not clear whether all of the participants were cared for by CNMs or whether some were cared for by physicians. Differences inherent in the two professions with regard to anticipatory guidance and client education during the antepartum period may have had an impact on the type of concerns expressed.

Sullivan & Beeman (1981) examined data taken from a state-wide mail-out survey of postpartum women conducted in 1979 by the Arizona Department of Health Services. The sample consisted of a total of 1900 women who had returned the questionnaire and represented Arizona's four major cultural groups. The 60-item questionnaire solicited information on socioeconomic and demographic features of the respondents as well as information on antepartum, intrapartum, and postpartum care. In the area of postpartum care, respondents were asked about length of stay, condition of their newborn, any specific

procedures and instructions they may have had and whether they had wanted them. In addition, respondents were asked for their opinions about desirability of a home visit and postpartum checkup.

In this secondary analysis of the data, the authors found a connection between decreased maternal satisfaction and lack of opportunity for parent-infant attachment, re-living of the birth experience, and teaching about infant and postpartum care. Ninety-six percent of 1,719 respondents indicated a desire for the opportunity to touch and hold their baby immediately after birth, over 79% of 1,531 respondents wanted an opportunity to discuss their birth experience, 95.3% of 1,699 respondents wanted information about baby care, and 97% of 1,710 wanted information about self care.

Thirty percent of the total sample indicated they would like a home visit. The topics they wanted addressed included self and baby care, fatigue and depression, family relationships, resumption of sex, and birth control. The responses did not vary significantly by parity.

There is one study evident in the literature conducted by nurse-midwives which tested an approach to facilitate maternal adaptation (Furr & Kirgis, 1982). A Solomon four group experimental design was used to

see if teaching mothers about their infants' newborn behavior made any difference in the mothers' adaptive behavior. Results showed a positive difference in the overall adaptive behavior of the mothers including sensitivity to cues, response to distress, and provision of growth-fostering situations. However, this study was not double-blinded posing the risk that researcher bias might have affected data interpretation.

Infant/Parenting Issues

Nurse-midwifery care of the postpartum client and her family includes facilitating the development of the infant-parental bond (ACNM, 1985). The data base and management plan for this generally includes: (a) assessment of infant feeding, maternal perception of the infant, and maternal coping with infant; (b) facilitation of parenting; and (c) anticipatory guidance regarding baby care, behavior, and breast feeding. Success in care taking ability will result in a feeling of competence and success in the caregiver. A first time parent may be so overanxious to perform adequately that the anxiety may inhibit alertness and responsiveness to infant cues. CNM intervention focuses on the parents' needs and provides support,

teaching, and anticipatory guidance to build mastery and confidence (Varney, 1987).

Marital/Family Relationships

Sexuality during the puerperium is one aspect of the marital relationship that has been studied by CNMs. Hames (1980) interviewed by questionnaire 42 first-time parents to identify their sexual needs and interests during the puerperium. The majority (62%) of both male and female respondents reported that breast changes and vaginal bleeding did not affect their sexual activity. They also felt that they were adequately prepared for these physical changes. Sixty-two percent of the couples had resumed intercourse before the six week postpartum check-up. More women than men reported worries about the effectiveness of their birth control method, perineal tenderness, harm to internal organs, fear of waking the baby, decreased lubrication, and fear of infection.

There are a number of difficulties in interpreting the significance of the data presented in Hames' study. The stated question of the study was "How do couples adjust sexually to the changes that occur following the delivery of a baby?" (p.313). However, the questions asked related to "informational interests of the couple with regard to their sexuality" (p.313). The question

posed does not match the information solicited, as "adjustment" implies a process, whereas "informational interests" implies a need for content.

Description of the methodology of the study is sketchy at best. There is no information in the published report on how the questionnaire was developed, tested, or designed, nor how or when it was administered. Sample selection and sociodemographic variables were not described which makes it impossible to assess the strength, limitations and generalizability of the findings.

There were no conceptual or operational definitions of the concept of sexual adjustment. Clear definitions would seem crucial to development of a questionnaire which seeks to assess such a complex physiologic and psychologic concept. It appears from the discussion of results that the questionnaires reflected the author's bias that physiologic changes were the only aspects to be considered in sexual adjustment in the puerperium. In spite of these problems, the study does indicate some of the physical concerns women and men have during the puerperium. The differences between what women and men worry about during this time was also discussed.

Fischman, Rankin, Goekin, & Lenz (1986) collected data on the changes in sexual relationships of 68 couples at four months postpartum and of 126 couples at 12 months postpartum. The sample was obtained by soliciting volunteers from childbirth education classes. Responses to the self-administered questionnaire revealed a reduction in the frequency and desire for sex when compared to prenatal activity. At four months, the majority of women reported several factors which interfered with sexual activity which included physical discomfort, decline in physical strength, fatigue, and dissatisfaction with body appearance. In addition, 43% of the women indicated that they had resumed sexual intercourse before their six week postpartum check-up. Generalizability of the study is limited by the fact that the majority of the couples were white, middle class, and employed.

Another aspect of family relations which has been addressed in the CNM literature is sibling adaptation. Kayiatos, Adams, & Gilman (1984) studied mothers' perceptions of their toddlers' regressive behaviors following the birth of a new sibling. In a telephone survey of 29 mothers, the authors found that 93% reported regressive behavior. The regressive behavior was most commonly associated with more recently

acquired skills. Toddlers who had been allowed to visit the mother and new sibling in the hospital had significantly fewer reported regressive behaviors than toddlers who had not. Finally, the authors found that 83% of the participants stated that their source of information about the adjustment of a toddler to a new sibling came from family, friends, or reading. Only 20% had received this information from their physician. Of the women who had not received this information from their physician, 92% indicated that they wished they had received it.

Summary

In an effort to determine the content of CNM care of the postpartum client, literature written by CNMs over the past twenty years concerning the puerperium was reviewed. This literature included research publications, review and clinical articles written by CNMs, the core competencies of CNM practice set forth by the ACNM, and Varney's (1987) textbook for nurse-midwifery. This body of literature has consistently described CNM care of the postpartum woman as development of a data base which includes: (a) evaluation of the physical, behavioral, and psychologic responses to child bearing; (b) continuing evaluation and management of the well-being of the woman; (c)

assistance with breast feeding, (d) facilitation of parenting; (e) anticipatory guidance and counseling; and (f) education based on individual family needs.

The complexity of the issues involved in the puerperium and the lack of a clearly defined outcome or endpoint are barriers to studying CNM care of the postpartum client. Despite these barriers, this literature review demonstrates that CNMs are beginning to focus independent efforts in the area of postpartum research. The strength of these studies has been limited by a lack of generalizability due to small sample sizes and lack of sociocultural diversity. These limitations support the need for continued research in this area. This need is underscored by the repeated description in the literature of the puerperium as a critical time in the life of a woman and her family.

Research to identify the process and content of CNM postpartum care is well justified by the paucity of such studies in the current literature, by the recurrent methodological errors of much of the existing research, and by the need for professional definition of the practice. The growing awareness that CNMs are not simply a different agent for the provision of women's health care, but offer a truly unique system of

care blending traditional medical care with the values inherent in the professions of nursing and midwifery, presents further justification for investigation of nurse-midwifery practice.

CONCEPTUAL FRAMEWORK

The conceptual framework for this study was based on Lehrman's model for describing the components of nurse-midwifery care of the antepartal client. Although other authors have attempted to define the components of CNM care, Lehrman (1981) appears to have successfully pioneered the operational definitions of the content and process of care. Lehrman's adherence to the CNM core competencies and literature as well as her use of grounded theory lend support to the validity of her theoretical framework. The present study proceeded on the assumption that Lehrman's framework could be applied to the study of CNM postpartum care.

The literature review presented here provided the basis for adapting Lehrman's framework to the postpartum period. It was postulated that some content components of care would remain constant in CNM care and could be translated directly from the antepartum visit to describe the postpartum visit. For instance, the eight aspects of nurse-midwifery practice which were defined by Lehrman and corroborated by the current

literature were incorporated without change. The physical examination, with obvious modifications focusing on the physiologic adaptations of the puerperium, was also included as a postpartum component of care. It was further theorized that other content components of care for the postpartum client would include: (a) a review of the client's activities related to developing parenting skills, (b) a discussion of topics related to health status, i.e., exercise and rest, return of menses, breast care, weight loss, emotions, sexuality/contraception, etc., (c) anticipatory guidance, and (d) adaptation to parenthood.

Process was conceptualized by Lehrman as the nature of the interaction between the CNM and client reflecting the approaches and attitudes assumed by the practitioner. The amount and nature of verbalization between client and nurse-midwife were identified as important elements of the process of care. Because Lehrman operationalized process with general categories of interaction, it was postulated in this study that the process components of care would be nearly identical in the postpartum interaction. Thus, it was expected that the components of postpartum care would include the following process components: (a) talking

and questions (initiated by CNM, client, and/or significant other), (b) presence of social conversation and laughing, and (c) the general order of the visit.

The framework developed for this study conceptualized many components of both content and process of CNM postpartum care. It was expected that data generated in this study would serve to confirm, refine, and/or elaborate on these identified components. In summary, the purpose of this study has been to describe postpartum care as delivered by nurse-midwives within the context of Lehrman's framework. The following research questions have guided this study:

1. What are the components of CNM postpartum care?
2. Can the components of CNM postpartum care be adequately identified using Lehrman's framework for the content and process of CNM care?

CHAPTER 2

METHODOLOGY

Design

The present study hoped to serve two purposes: (1) contribution to clinical knowledge by identifying the components of nurse-midwifery postpartum care and, (2) contribution to theoretical understanding of the process of nurse-midwifery practice by extending Lehrman's work on a nurse-midwifery practice model to postpartum care. Therefore, the study has employed a descriptive, exploratory design with both a qualitative and quantitative approach to data analysis in an attempt to identify components of postpartum care as provided by CNMs.

Sample

The sample was non-random and purposive. Certified nurse-midwives practicing in Northwest Oregon were solicited by mail for participation in the study. The participants were selectively chosen from those nurse-midwives who indicated an interest in the study. This selection resulted in six participating CNMs representing three separate nurse-midwifery services.

Because it was assumed by the researchers that a practice approach is acquired over time, only those midwives who had been in practice at least 18 months

were eligible for the study. All participating CNMs provided postpartum care as a part of their routine, full-scope services. Other criteria for eligibility included: (a) willingness to tape-record a postpartum visit, (b) completion of a consent form and demographic questionnaire, (c) and assistance with soliciting clients for participation if needed.

Criteria for client eligibility were: (a) the use of English as the primary language, (b) presentation for their first postpartum visit with a CNM who provided some portion of their prenatal or intrapartum care, (c) willingness to have that visit audio-recorded, and (d) willingness to complete consent and demographic information forms during an interview with one of the student researchers. Although Lehrman limited her sample to primiparous women this study included both multiparous and primiparous clients as eligible participants. This choice reflected the researchers'assumption that analysis of interactions between clients and CNMs might reveal different components based on the client's parity. In addition, exclusion of multiparas might have prevented the sample from reflecting the broad spectrum of CNM care.

The researchers recognized that the time and setting of the visit could have an influence on the

nature of the interaction and the data which was generated. For example, if the first postpartum visit was a home visit at 24 hours after birth it could be expected that the topics discussed and the nature of the physical exam might be different than a first postpartum exam which took place at six weeks in the CNMs office. The original design of the study assumed that components of CNM postpartum care would most thoroughly be described if a variety of settings were studied.

Data Collection

As has been mentioned, the method of data collection was audio-recordings of postpartum visits between nurse-midwives and their clients. While participant observation may have been the ideal method of data collection, the time required for it prohibited its use for this student research project. There was also the concern that the presence of an observer might alter the exchange between the nurse-midwife and client more than the presence of a small and unobtrusive tape recorder. Video-recording was also rejected due to the technical complexity and cost of the equipment.

One of the problems noted by Lehrman was the poor quality of some of the tape recordings. In and attempt to limit this potential problem, high-quality tapes and

recorders were used and the researchers set up and tested the equipment prior to the arrival of each client. Despite these measures, the first tape recording was of such poor quality that its data was technically inaccessible. This motivated the researchers to set up two tape recorders at each visit, yielding two high quality audio recordings of each of the remaining five visits.

Demographic characteristics of the CNM and the client were gathered through a brief questionnaire, administered after the completion of the visit to avoid skewing the data. Characteristics of the CNMs included age, years in practice, type of services offered, and setting of practice (See Appendix C). Those of the clients included age, marital status, ethnic background, income level, educational background, parity, method of delivery and brief description of labor and delivery experience, delivery data, and information regarding prenatal childbirth education (See Appendix D).

Protection of Human Rights

Prior to data collection, permission to study human subjects was obtained from the participating institutions. Consent forms were approved by the Committee on the Study of Human Subjects, Oregon Health

Sciences University, prior to administration. No research was conducted without informed consent from both CNMs and clients, with options for both parties to withdraw from the study at anytime (See Appendices E & F).

To assure anonymity, a code number was assigned to each tape and transcription, and names mentioned on the tapes were deleted in the transcription. The tapes were erased after data analysis and study results will be made available to participants and participating agencies upon request.

Data Analysis

The data analyzed were qualitative in nature being primarily narrative rather than numerical. Data generated from the recorded postpartum visits were analyzed by listening to the tapes and reading through their transcriptions. It was anticipated that certain elements of the CNM/client visit, such as specifics of the physical exam, would only be obtained from documentation on the chart. Thus, further data consisted of information on the Chart Review Form (Appendix G).

Whereas Lehrman utilized grounded theory and qualitative analysis (Glaser & Strauss, 1967; Swanson, 1986) to develop and conceptualize the components of

care without any established definitions, this study utilized the definitions that emerged from Lehrman's work to analyze the components of postpartum care as provided by CNMs. The tool adapted from that of Lehrman (Appendix H) served as the guide for data analysis. The data that did not fit this adapted tool was coded, categorized, and defined by consensual agreement of the researchers using a form of grounded theory methodology similar to that used originally by Lehrman.

The individual researchers initially reviewed each transcription, as well as its tape. This separate analysis was an attempt to enhance interrater reliability. As content and/or process components of care outlined by the adapted tool were recognized, they were coded as such on the transcriptions. For instance, if the CNM provided the client with specific information related to infant feeding, that interaction was coded on the transcription as Education and Counseling, one of the eight aspects of CNM care identified by Lehrman.

The researchers divided themselves into two paired groups to facilitate initial discussion of the analyzed data. The paired researchers compared their separate analyses and attempted to achieve agreement as to the

presence or absence of the anticipated components of care. In the few instances where there was significant disagreement, discussion and negotiation continued until agreement was reached as to the way in which the data were to be categorized.

Each of the five audio recordings was also reviewed separately in search of specific components of care which were not evident in the transcriptions. Because certain process components of care, such as the tone of voice and/or periods of silence were not clearly represented by the transcriptions, this guided review of the audio tape completed the data analysis of each visit.

After both pairs of researchers agreed that their analyses were complete for each visit, the four researchers as a group compared and discussed their findings. When data emerged that did not fit the adapted tool, the four researchers came to agreement as to the nature and name-code of the phenomenon identified. These codes were then collapsed and any modifications and/or additions to the existing tool were made.

CHAPTER THREE

RESULTS

Presentation of the results of data analysis will begin with a description of the sample followed by a summary of the components of nurse-midwifery postpartum care identified which were consistent with those expected based on Lehrman's (1981) framework. These findings will be organized according to the adapted measurement tool (Appendix H) and grouped according to content and process components of care. Additional findings not well defined and/or measured by the existing tool will then be presented. Results presented represent analysis of the five taped visits which produced satisfactory recordings. The sixth taped interview in which significant portions of the interaction were technically inaccessible for analysis was not included in the analysis.

Sample

The final population of clients for this study consisted of five women receiving care from three separate nurse-midwifery services. The women ranged in age from 23 to 30 with a mean age of 26.6. Three of the women were married, one was single and living with a partner and one client was separated. Educational levels ranged from a GED (1) to High school graduate

(3) to a baccalaureate degree (1). The majority of the client sample was white (4/5) and multiparous (4/5) (See Table 2).

All clients indicated that the CNM had provided a significant portion of their antepartum care and four of the five clients were attended at birth by the CNM providing the postpartum care for this visit. The only client who indicated participation in childbirth education and/or childcare classes was the woman who gave birth to her first child. None of the clients indicated specific prenatal preparation for postpartum transitions.

The sample of five nurse-midwives for this study represented three separate practice settings: (a) a hospital based group practice in which the CNMs are employees of the hospital; (b) an independent CNM partnership providing home births, and (c) a private CNM and MD joint practice with hospital as the birth site. One midwife from the home birth practice and two from each of the other practices participated in the study. Demographic information for the sample of CNMs is presented in Table 3.

All three of the CNM practices provided full-scope services to their clients, i.e., antepartum, intrapartum, postpartum and intraconceptional care.

Table 2

Demographic Characteristics of the Client Sample (n=5)

Characteristics	Client
Age	
Range	23-30
Marital Status	
Married	3
Single/Living With	1
Separated	1
Race	
White	4
Black	1
Educational Level	
<12 (GED)	1
12-15	3
College Degree	1
Parity	
Multiparous	4
Primiparous	1
Income Level	
Range	Welfare to $80,000/yr

Table 3

Demographic Characteristics of the Nurse-Midwife Sample (n=5)

Characteristic	Number of CNMs
Age	
Range	34-42
Years in Practice	
Range	2-6
Basic Nurse-Midwifery Education	
Certificate	0
Masters	5
Highest Degree Held	
PhD	0
MS	3
MN	2
Type of Practice	
Private; CNM group/Solo	1
Private; CNM & MD Joint Practice	2
Hospital Based/Employee	2

Only the home birth service included newborn care. Two of the CNM practices provided services to a client population with a wide range of incomes. The hospital based CNM group was strictly limited to providing care to low-income women insured by the hospital Professional Care Organization (PCO).

The CNMs ranged in age from 34-42 (M=39.4) and years in practice ranged from two to ten (M=5.5). Two of three services provided immediate postpartum services to their clients in hospital prior to discharge. Similarly, the home birth practice provided assessments to its clients at home in the immediate postpartum period (24 and 72 hours) which was comparable with the in-hospital care of the other services. The home birth and hospital-based practices scheduled first follow-up postpartum visits at two weeks; the other service scheduled the first visit at one week. All three services scheduled final postpartum visits at six weeks.

The CNM questionnaire included an open-ended question asking the CNMs to describe their routine postpartum follow-up care and services. None of the nurse-midwives suggested any content categories of CNM care which had not already been incorporated on the tool for analysis of components of postpartum care.

Content Components

Aspects of Nurse-Midwifery Practice

A general analysis of the five transcripts and audio recordings lent credence the existence of the eight aspects of CNM care as conceptually and operationally defined by Lehrman. Six out of eight of the aspects were present in all five of CNM/client interactions. Table 4 presents a summary of the number of visits in which each aspect is present, the range of incidents of each aspect within a visit where present, and the mean for the visits where present. Lehrman's conceptual definition of Time was "The subjective feeling that the health care provider is unhurried and will vary the period of interaction according to the client's needs" (Appendix B). The subjective feeling of an unhurried interview was evident in all the interviews as shown by the researchers subjective responses such as "relaxed feeling", "easy give-and-take", "numerous pauses on part of CNM", and "sense of patience on part of CNM". In addition, there were numerous instances in all the visits in which the CNM would insert social comments such as "How's that road of yours?" or "What a great dress!". The CNMs also varied the length of the interaction based on what the client appeared to want.

Table 4

Analysis of Aspects of Nurse-Midwifery Practice Content Categories in Five Postpartum Visits

Aspect	Number of Visits	Range	Mean
Time	5	15-37′	26.6′
Continuity of Care	5	1-3	2
Education and Counseling	5	6-11	9
Noninterventionist Care	3	2-5	3
Flexibility	4	1-6	3
Participative Care	5	1-4	2.8
Consumer Advocacy	5	2-4	3.2
Family Centered Care	5	5-10	7

For example, in one interview an extensive discussion on a client's chronic problem with headaches was encouraged by the CNM through the use of comments such as "Oh?" and "Yea, ok" which allowed the client to ventilate her feelings.

The operational definition of Time was the duration, in minutes, of the audible encounter between client and CNM. The postpartum visits between CNM and client lasted for an average of 26.6 minutes with a range of 15-37 minutes. This was found to be very similar to the mean and range for the prenatal visits measured by Lehrman (1981, p.32).

Education/Counseling and Family Centered Care were the two most frequently identified aspects of care. They occurred on the average of 9 and 7 times per visit respectively.

It was difficult to find any instance of Education/Counseling which met the strict operational definition in Lehrman's study of "The occurrence of at least one 1-minute period, which is continuous, during which the CNM discusses one subject with the client for the purpose of teaching, counseling, or instructing" (Appendix B). All occurrences of Education and Counseling tended to last less than a minute and frequently were interspersed with comments by the

client. In the following example, the client had expressed a concern about discharge from her baby's eye.

CNM: Ok,...sometimes babies have these blocked tear ducts and some babies get really gunky eyes and their parents are really nervous that it's an infection or something. But as long as it's clearish to yellowish discharge and there's no redness and swelling underneath the eyelid?

Client: Uh huh

CNM: or down under here? It's generally just a blocked tear duct.

Client: Yea

CNM: So what you do is, real gently, or with some pressure actually, you push this way to express it and to pump open the tear duct...

Family Centered Care was easily identified in a number of visits when the CNM asked about siblings, partner, finances or discussed infant care issues. For example, "Well, what did your kids think (of the birth)? Was it a good experience for them?" and "...did you tell WIC that you are formula feeding now? So you can get vouchers?"

Continuity of Care, defined as those instances in which the CNM refers to past services or plans for

future care, was present in all five interviews with a mean frequency of two instances per visit. The most frequent example of Continuity of Care was the CNM arranging for follow-up visits: "Yea, let's schedule you back in a week...", although there were also references to past care: "And did you decide to have the tubal?".

Participative Care, operationally defined as "...mutual collaboration on a matter between the CNM and client to reach a decision or conclusion; or, ...where the client is involved in an/or takes responsibility for a portion of her health care during the visit" (Appendix B), was also present in all five interviews with a mean frequency of 2.8 instances per visit. In one interview the client expresses a concern with her infant's difficulty latching on to the left nipple.

CNM: Do you think - uh - is the nipple unusually shaped?

Client: Um. I think it is a little bit...I'm not sure what the problem is.

CNM: Have you tried turning him upside down and seeing if that's -

Client: Yea

CNM: It isn't a side problem?

Client: No. It's not. I thought that that might work and it helped when I was starting to get plugged up. That really helped, but it doesn't really help him get the nipple.

CNM: Can we try anything else?

Client: No, and I've tried other things. So, I know we can do it and I know he'll eventually get the hang of it - but that's still a problem for him.

CNM: Well, you've got to hang in there. The other kids had the same problem and now he's doing it just like they did, Right?...

Consumer advocacy as defined by Lehrman was evidenced by "the occurrence during the taped visit of at least one incidence where the CNM provided encouragement, emotional support, or positive feedback to the client regarding the client's decision in her own health care or that of her newborn" (Appendix B). In one interview the CNM supported the client's choice to use antibiotics in the treatment of a suspected perineal infection: "So you're doing alright, I think you made the right decision to take the antibiotics and keep taking the other things, the vitamin C...". In another interview the CNM upheld and supported the

client's desire for a tubal ligation and her interim use of foam and condoms:

CNM: ...What are you going to use for family planning?

Client: ...I would guess condoms and suppositories...

CNM: Ok

Client: I was hoping to get my tubes tied.

CNM: Ok, and we're going to set that appointment up? Is this the time?

Client: Yea

CNM: Alright. You can use that (condoms and suppositories), as long as you're going to have your tubes tied within the next month or so, that's probably the best.

Flexibility was operationally defined as those instances in which the CNM offered the client possible alternatives to meet her needs. Four out of five of the transcripts contained evidences of Flexibility of Care, present on the average of three times per visit. A good example was the CNM offering different solutions for a client who was having difficulty falling back to sleep after waking to feed the infant:

CNM: Ok, there's a couple things you could do. Number one, you can just accept that and say 'Ok,

well, that's the way it is and I'll get used to it'. The other thing you can do is if you're really awake, is after he's done nursing, number one, try to wake him up a little more and nurse him on the other side? ...or you can put him more on P's (spouse) side, because sometimes they just smell the milk - they're so close to the milk, you know...or you can get him in the habit of putting him in a little bassinet that's down beside you or you put it up on a level that's level with the bed - and then you don't have to be reaching out of the bed and stuff like that...

Non-Interventionist Care, those instances in which the CNM offered non-medication treatments, was present in 3 out of 5 visits, appearing on the average of three times each visit. An example from the data representative of this aspect of care was the CNM responding to a client's request for hormones to dry her milk with a suggestion that binding her breasts might be more effective at this time.

Client: I might need some pills or something to dry them (breasts) up because once I got home I - it wasn't really convenient to keep breastfeeding.

CNM: So you're not breastfeeding al all now.

Client: No, I'm only formula.

CNM: Ok. It will go away. If it's bothering you a lot, get a tight bra, or else bind them, you know, with, like a baby blanket?...There's no medicine that will make it stop now. So just go ahead and tighten them up and some people find it helps if you pump and some people find it helps if you just don't mess with them at all and just not stimulate them at all.

Another example was the CNM's suggestion of using breast milk for cleansing an infant's eye when it was assessed the tear duct was slightly clogged: "Some people wash their baby's eyes out with breast milk and some people use plain water and some people use raspberry leaf".

Analysis of the visits also revealed a number of instances where the individual aspects of nurse-midwifery practice seemed to overlap in the interchange between CNM and client. For instance, Flexibility, Noninterventionist Care, and Education/Counseling overlapped in one CNM's response to the client's questions regarding the practice of douching.

You might try not douching for awhile and see if you don't have as many infections. It doesn't do

> anything about the syphilis. Douching doesn't help or hurt that, because that's in the blood, that's totally different (Education). Uhm, ok, so what I would say about douching is if you really feel like you need it too, make sure you use some vinegar (Flexibility and Noninterventionist). Some women do it once a month after their period stops. Or you might just try not doing it as much after sex and see how it goes (Flexibility). Uhm, and yes, yeast infections are helped along by eating a lot of sugar and keeping real damp down here and wearing nylon panties and stuff (Education). So if you don't eat very much sugar and you wear cotton panties...(interrupted by client agreeing with CNM)

In the instances of simultaneous occurrence of different aspects of care, they were tallied as individual phenomena.

The demographic questionnaire included an opportunity for the participating CNMs to narratively describe what they believed was unique about postpartum care as provided by nurse-midwives. Their responses lend further support to the existence of the aspects of nurse-midwifery practice as defined by Lehrman. For instance, four of six responding CNMs stated that the

amount of education and counseling provided was unique to CNM care. This was reflected in such statements as "More teaching", "Education, education, education!!!", "More counseling/teaching" and "Detailed teaching".

Participative Care was suggested in comments by two of the CNMs: "Involvement of client and her support in care and health care decisions" and "Family involvement". These comments as well as such statements as "Holistic integrated approach to enhance physical, mental and social health of the newly increased family" might also reflect Family Centered Care as defined by Lehrman. Other responses by the CNMs such as "personalized/individualized" by three CNMs and "flexible" by two of the CNMs also suggest that these nurse-midwives appear to include Flexibility of Care. Time as an aspect of nurse-midwifery care was supported by two participants who stated that "more time" was a unique characteristic of their postpartum care.

Physical Examination

Using the tool adapted for postpartum care from Lehrman's prenatal tool, analysis revealed that these first postpartum visits consistently included blood pressure and weight but that the presence of further physical assessment was variable and primarily related

to individual needs of each client. For example, in one interview the CNM examined the breast of a client who indicated she was having a breastfeeding problem and in another interview the CNM examined the perineum of a woman who was being treated for a perineal infection. The only visit in which a more complete exam was done more routinely was a 12 day postpartum visit after a home birth.

Client Participation in Parent Education

This topic was not addressed in any of the five interviews. It was included on the tool as an adaption of the category of "Client Participation in Prenatal Education" on Lehrman's (1981) original tool.

Topics Discussed

A summary of the topics discussed in five postpartum visits has been presented in Table 5. The figures reflect the number of postpartum interactions in which the specific content components were present.

Health Status

The only health status topics which were discussed in all five of the visits were interim history and exercise/rest. Many of the other health status components identified on the postpartum tool were present in more than one of the visits. For example,

Table 5

Analysis by Content Categories of Topics Discussed in Five Postpartum Visits

Topic	Number of Visits When Present
Health Status	
Interim History	5
Danger Signs/Complications	4
Exercise/Rest	5
Bowels/Hemorrhoids	1
Explain Illness	4
Involution	1
Return of Menses	2
Postpartum Discomforts/Relief	3
Lab tests/Results	2
Nutrition/Diet History	3
Breast Care	1
Weight Loss	3
Blood Pressure/Vital Signs	0
Concerns	
Self (Physical/Emotional)	4
Infant (Feeding, Behavior, etc.)	4
Spouse/Partner	3
Siblings	1
Other	2
Sexuality/Contraception	5
Other Topics	3
Anticipatory Guidance	
Self	4
Infant	3
Spouse/Partner	1
Siblings/Other	0
Treatments	
Vitamins/Iron	1
Other Medications	2
Other	2
Adaptation to Parenthood	
Labor and Delivery Experience	3
Feelings Toward Infant	3
Family Adjustment	4
Support System	3
Stressors	4
Coping Strategies	3
Emotions/Depression/Blues	2
Facilitation of Parenting by CNM	4

review of at least one of the danger signs and an explanation of illness were jointly present in four of the visits. Postpartum discomforts, lab tests, nutrition and weight loss were comprehensively covered in three of the visits.

Two descriptions were found to be inadequate for identification of components present in the postpartum interaction For example, the category of involution was addressed indirectly by discussions of lochia or the size of the uterus. Breast care was not discussed as such, but the breasts were talked about in relation to breast feeding and milk production.

Concerns

A discussion of some form of client concern was present in every postpartum interaction. These concerns included those the client had about herself, her infant, her spouse or partner, siblings and other family members. The most common physical concern expressed by clients was that of rest: "Up all day - up all night. He keeps me up all night and they (other children) keep me up all day. I'm exhausted." Concerns about the baby included breastfeeding problems and sleep: "He has a real hard time getting the nipple on that left side.", "I'm trying to get him to be a little more awake during the day but it's not really

working." In two interviews, circumcision was discussed: "I really don't want to do it. One in a million babies looses his penis. What if mine is the one in a million?" and "Making the decision about the circumcision and then doing it was really hard."

A husband's response to the new baby was discussed by one client: "Um...He hasn't warmed up to T. (baby) yet or spent much time with T. yet because he's been helping out with the girls..." and the CNM acknowledged a significant transition for another client whose husband had recently moved back into the home:

> You've had a pretty major transition here. With what life was like before...its got to be a little difficult for him (spouse) coming back in...having not been there he missed a lot of all the stress and I can't believe it's not there now that there's two of you trying to adjust to each others expectations.

Concerns about siblings were discussed with three of the four clients who had other children. These discussions were initiated by the CNM in two: "How are your other kids getting along?" and "Well, what did your kids think about the (birth)? Were there any more - you know - was it a good experience for them?" In

the third interview, the client alluded to a sibling's reaction to the baby's crying:

Client: K. says 'shut her up!'

CNM: Get her to help. Tell her to go pat her on the back - tell her 'mommy's coming, mommy will be right here.

The most frequent concerns spontaneously introduced by the client were about herself (present in all of the visits) and her infant (present in four of the visits). The tool did not distinguish between concerns spontaneously introduced by the client and those elicited by the CNM. For this analysis, both were included and represented as such in Table 5.

Sexuality/Contraception/Other

Analysis identified discussions of contraception and the resumption of sexual relations in all of the visits. One client commented, "I haven't started having sex yet. I wanted to get checked out first. My husband came to visit me and I wanted to do it." and another asked, "When is it safe to have sex?".
The CNMs differed individually in the extent to which sexual behavior and feelings of sexuality were discussed. For example, although contraception and resumption of sexual activity was addressed in all visits, only one CNM talked about sexuality beyond it's

relationship to contraception. In that interview, the CNM discussed alternatives to vaginal sex and coping with a partner's desires:

> CNM: So there's just lots of different kinds of sex, and if that's ok for you, I'm saying that's fine, you know. If it's not ok for you emotionally, you don't want to do that...Sometimes men will say, 'Oh come on,' you know, 'let's do this' and you go 'ok, you know, I'll make love with you tonight with my hands' or something like that. There's other ways to have sex than just penis in the vagina. Cause the guys really push hard sometimes after the baby's born (joint laughter).

Topics discussed which were placed in the "other" category on the tool included positive health behavior, douching, drug screening, urination, WIC (Women, Infants, & Children Nutrition Program), and CSD (Children's Services Division). Each of these only appeared once in four of the five interviews.

<u>Anticipatory Guidance</u>

There was some discussion representative of anticipatory guidance in four of the transcripts. These discussions were predominantly related to the client herself or the infant. For example, in one

visit the CNM discussed engorgement, weaning, lochial changes, and the economic benefits of breastfeeding. In another the CNM instructed the client in the proper care of her infant's umbilical cord. This interaction represented another example of the overlap of aspects - Anticipatory Guidance and Education/Counseling.

Treatments

Treatments discussed in the visits included vitamins and iron supplementation (one visit), other medications (two visits), foam and condoms (two visits) and sitz baths (one visit). As with anticipatory guidance, treatments and/or interventions were not emphasized and tended to reflect the individual needs of the client.

Adaptation to Parenthood

Reference to adaptation to parenthood was present in each of the five visits. The most frequently discussed issues were family adjustment, stressors and facilitation of parenting (four out of five) followed by coping strategies, labor and delivery experiences, and support systems (three out of five). The remaining issues ("feelings toward baby" and "emotions, depression, blues") were discussed in two out of the five visits. There were no topics listed on the tool under adaptation to parenthood which were not discussed

in at least two of the visits nor did any new topics emerge from the data analysis.

Data coded as family adjustment included instances in which the CNM solicited the client's perceptions of various family members' reactions to the birth experience, the new baby, role transitions, and/or altered family dynamics. Identified stressors included such issues as finances, physical changes or discomforts of postpartum, time management and rest.

Facilitation of parenthood was defined as any interaction in which the CNM modeled positive behavior in an interaction with the infant or provided positive support/reinforcement of the client's appropriate parenting behaviors. This frequently took the form of the CNM cooing and talking affectionately to the infant or assisting the client in responding promptly to the infant's needs during the visit. For example, during one visit the infant was brought into the exam room by his father for a diaper change. The CNM shifted her focus to assisting the parents in changing the diaper and commiserating with the father (whose shirt shared the fate of the infant's diaper), and supplying humor, patience, and wash cloths:

Client: He did poop all over his daddy.

Husband: (laughing)

Client: What a good boy!

Husband: (laugh) Oooo eee!

CNM: You need to call him 'Squirters'.

Client: Yea

CNM: You hear that little squirt noise and you start holding the baby away from you.

Client: My breast milk - my breast milk is making him runny.

CNM: Well that's perfectly normal. Normal breastfed baby stool.

Husband: Does he want to eat?

Client: No, you're going to change him.

Husband: I need to change myself.

Client: It's just a little bit of poo.

Husband: Boy, he really pads it in. He gave me a lot.

CNM: Yea, that's so frustrating when you've got everything changed to clean and then (laugh)

Client: ...I need something to wipe him with - he's pretty gross.

CNM: We don't have Daisy Wipes but I'm sure they have them on the unit.

Client: I have some but I'm sure they're dried out by now. So...

CNM: I'll get the water warm.

All but one of the five clients studied were nursing their infants and the problems they presented were typically related to breastfeeding issues and/or sleep and rest:

> CNM: You just don't like it (breastfeeding), or what was the problem?
>
> Client: At first, because I was in so much pain once I got home I just couldn't take it, you know, and I just start - taking those Tylenol she had given me and I was just drowsy and sleepy so I wasn't up to par when I got home....I was sayin 'I got pains all over, boy, this is one pain I could lose right here (laughing) - cause he's just (mimics sucking, chomping noises).

And in another interview:

> CNM: Do you fall asleep with him nursing (at night)? Are you that comfortable?
>
> Client: No, uh - Yea, yea. Most of the time I do and last night when he - sometimes he when he wakes me I have a lot of problems getting back to sleep.

Discussion of support systems generally referred to spousal and extended family assistance with daily chores such as meal preparation and child care.

Client: And W. (spouse) is back on the road and the usual. So I'm on my own with four children now.

CNM: Huh.

Client: And he - you know, he gets home at 7 o'clock or for two nights this week he's out to dinner so he doesn't get home 'til 11 and um - so it's - so I figure I have a good reason to be depressed and tired. And it's not real bad but it's going to take a few weeks -

CNM: Well yes, and you're home all day fitting into a new schedule and all that. I mean that partially a lot of women feel just that - I mean that's normal and you have other reasons to feel that way. I mean you don't have as much support at this time, when you have another child.

Client: But I'm getting some help. My mom comes next Thursday, and she'll be here about 10 days so that will help me finish organizing...

Discussions of labor and delivery experiences occurred in three out of five of the visits, generally taking place briefly and quite early in the visit. All but one of these clients had been assisted in delivery by the CNM conducting the interview. The flavor of these discussions was that of praise and validation of

the client's effort and experience during parturition. Two of the women spontaneously expressed pride in their performances, which was supported by the CNM. The following is an example of one of these interchanges.

Client: I did so good.

CNM: You really did you were doing everything right. Well, you should be real proud of yourself, you were great.

Client: I am, I did good.

The remaining issues, "feelings towards baby" and "emotions/depression/blues" were found in a total of three visits. In two interviews, these topics were initiated by the client, in the other the CNM introduced the subject by commenting on the baby's sex (a desired boy after three girls). In only one interview were both topics discussed.

Summary of Content Components

Although there was some variation in frequency of occurrence, all eight aspects of nurse-midwifery practice as defined by Lehrman (1981) were evident in the data collected. While specific elements of other content areas were variable in occurrence and frequency, there were elements from each main category (ie. Physical Exam, Topics Discussed) in the majority of visits. The data did not reveal any new content

areas, however certain elements which had not been specifically identified in the tool, such as discussion of lochia and breastfeeding issues, were present in the majority of the visits.

Process Components

Process

Process components identified in the tool included the presence of talking, questions, and social conversation by CNM, client, and significant other as well as silence, interruptions, and incidents of poor or inaudible recording (see Table 6). Not surprisingly, there was ample evidence of talking by the CNM and client in every visit.

In three out of five visits, the client came unaccompanied by her spouse (or significant other). Of the two who were accompanied, one partner remained in the room during the visit and one came in briefly to attend to infant needs. There was evidence of talking by the spouses in both of these instances. However, because only one spouse was actually involved in a visit, analysis of process data related to participation of a partner/support person was considered not significant (NS).

Incidents of the CNM asking questions were present in all five of the interviews. For the purposes of

Table 6

Analysis of Process Components in Five Postpartum Visits

Process Component	Number of Visits When Present
Process	
Talking by CNM	5
Talking by Client	5
Talking by Significant Other (S.O.)	2
Silence	5
CNM Asking Questions	5 Range: 17-71 M=33.8
Client Asking Questions	5 Range: 2-15 M=9.2
S.O. Asking Questions	NS
Social Conversation by CNM	3
Social Conversation by Client	3
Social Conversation by S.O.	NS
Unable to Understand Details of Conversation	4
Interruptions	2
Initiation of Subjects	
New Subjects by CNM	5 Range: 6-16 M=11.4
New Subjects by Client	5 Range: 3-14 M=7.2
New Subjects by S. O.	NS
Questions by Client not Answered by CNM	0
CNM asks if Client has Questions	3
Emotional Tone of Visit	
Incidents of Laughter	5
Incidents of Crying	0
Incidents of Reassurance	5
Incidents of authoritarianism	0
General Order of Visit	
Talking/Exam with Talking/Talking	4
Any Other Order When Exam Present	0

analysis, questions were defined as those instances in which specific information was being sought. Communication techniques intended to encourage the client to elaborate on or corroborate a statement, ie. "Oh?" or "Right?" were not counted as questions in this study. The number of questions asked by the CNM ranged from 17 - 71 with a mean of 33.8 questions per visit.

Questions asked by the client were also present in all five interviews with a range two to 15 and a mean of 9.2 questions per visit. The spouse who did participate in the visit asked a total of two questions during the interview.

Social conversation by the CNM and by the client was present in three of the interviews. Silences were defined as pauses lasting more than five seconds and were evident in all five of the interviews. Interruptions were defined as those instances in which some one or some thing not a part of the visit temporarily halted the interview. One interview was interrupted by a father coming in to get the baby changed and another interview was interrupted twice by telephone calls.

Instances in which details of the conversation were difficult to understand occurred in four of the five visits. All of the instances were brief and

frequently were during times of laughter and evident joking on the part of both CNM and client.

Initiation of Subjects

New subjects were introduced by the CNM during all five interviews, with a range of six to 16 new subjects per visit and a mean of 11.4. New subjects introduced by the client were also present in all five interviews (range of three to 14, mean 7.2). There were no incidents in which a question asked by the client was not answered by the CNM. The CNM asked if the client had any questions in three of the five interviews and in one of the three interviews this question was asked twice during the same visit.

Emotional Tone of the Visit

There were numerous incidents of laughter on the part of both CNM and client on all five tapes and the only incidents of crying were on the part of infants seeking comfort. The CNM's frequently offered reassurance to their clients in all five interviews. Authoritarianism was defined as instances in which the CNM unequivocally stated or implied that the client should accept without question the CNM's plan of care. This behavior did not occur in any of the five visits.

General Order of the Visit

General order of the visit referred to the order

in which the basic elements of the visit, talking by the CNM and/or client and a physical exam, occurred and their relationship to each other. Examples listed on the tool included whether talking preceded the exam, continued through the exam, and concluded the visit, whether the talking ceased during the exam, or whether the exam was done at the start of the visit.

Four out of the five visits included an exam beyond the assessment of vital signs. In these interviews, the general order of the visit was "talking/exam with talking/talking". In one visit, the CNM included the partner in assessment of the fundus and enlisted his aid in the ongoing evaluation of normal involution. Because the exams when present were generally brief, possibly reflecting both the early nature of the visit as well as individual client need, general order of the visit did not seem to be a significant process component in these visits.

Evaluators' Subjective Reaction to Visit

As in Lehrman's instrument, the end of the tool had an open section for evaluators to write in their subjective responses after listening to the tapes of the interview. Listening to the tapes provided numerous instances in all five interviews in which the client's feelings towards her infant could be

subjectively assessed by tone of voice, comforting efforts, and mother/infant interactions. Similarly, the emotional status of the client could be subjectively assessed as well as the CNM's response to stated or implied emotional needs. Thus, although video recording or participant observation as methods of data collection would have provided greater depth of assessment of the interaction between client and CNM, the ability to discern emotional tone of the relationship did not seem compromised through the use of audio recordings.

The most consistent response of the individual evaluators to all five visits was to note the relaxed, friendly, and supportive tone of each CNM. Other responses included "genuine concern for client", "agenda appears to reflect the needs of the client", "easy give and take", "frequent use of humor/laughter", and "patience". Subjective responses by all four of the researchers also included descriptions of a sense of "connectedness, empathy, mutuality, intimacy, familiarity, warmth, acceptance, and patience" in the relationship between CNM and client.

Inclusion of subjective responses of the evaluator on the tool for identification of components of postpartum CNM care provided the researchers with the

opportunity to compare their assessment of components which were perhaps not well measured by the tool. Because the independent analysis revealed similar subjective responses, the researchers were prompted to pursue the analysis for recurrent themes related to the nature of the relationship between the CNM and client. The findings of this analysis will be discussed in greater depth in the following section.

Additional Findings

In addition to the components of CNM care previously identified by Lehrman (1981), this analysis of five postpartum visits revealed the consistent presence of new components related to both content and process. Although a few of the new concepts were felt to be a part of content, the majority seemed to fit more comfortably as process components as they reflected the nature of the relationship between the CNM and client. The following is a discussion of these additional findings.

Broadening of Aspects

Analysis of the transcripts suggested that interchanges between the CNM and client which appeared representative of education and counseling and continuity of care were identified independently by each of the researchers. However, strict adherence to

the operational definitions would not allow for coding of these specific data bits.

For instance, Lehrman's operational definition of Education and Counseling required "the occurrence of at least one 60 second period which is continuous during which the CNM discusses one subject with the client for the purpose of teaching, counseling, or instructing" (Appendix B). Analysis and coding revealed numerous interchanges between CNM and client which did not last for a continuous minute and yet it was clear that the purpose of the communication was teaching, counseling or instructing. An example of this was the advice given about the baby's blocked tear duct which did not last a full minute, but was clearly educational counseling. Thus the present data analysis suggests that for the purpose of identifying education and counseling in the postpartum period the time limitation might be broadened.

Continuity of Care was operationally defined as "the occurrence of at least one reference to past care or one plan for future care." Analysis of the postpartum visits suggested that a broader definition of care to include the existing relationship between the CNM and client rather than only the services provided would account for some of the data generated

in the tapes. This expanded definition would then be evidenced in instances in which the CNM referred to previous exchanges not directly related to care provided but clearly indicating continuity. For example, in one interview the CNM spontaneously asked "Are you still sleeping downstairs or did you move upstairs to go to bed?" and in another interview the CNM responded to a client's comment that she hadn't had any intercourse recently with, "Cause you were separated right before you delivered, right?". These were typical of comments which indicated the CNM had had previous contact with the client, and were, therefore, indicative of continuity.

New Findings

Initial coding of the transcripts by the individual researchers revealed several statements and/or responses by the CNM perceived by the researchers to be significant and codable but not consistent with Lehrman's (1981) framework. Although elements of these codes could be found in some data that conformed with Lehrman's operational definitions, many more pieces of data did not. For example, one of Lehrman's aspects, that of Consumer Advocacy, did refer to the CNMs use of "encouragement, emotional support, or positive feedback", but it was specifically related

to those times in which the CMN was supporting a health care decision made by the client.

Coded interpretations of these interactions included such findings as the frequent use of affirmation, validation, reassurance and supportive statements by all of the CNMs. There was repeated use of humor, encouragement, clarification, probing and active listening on the part of the nurse-midwives. In addition, in all the transcripts, there were numerous incidents in which the CNM conveyed a sense of shared experiences, expressed empathy, and aligned herself with the client. This was especially apparent in discussions about the changes and problems brought about by becoming a parent.

Statements representative of affirmation include "You're incredible" or "Wow, those are great nipples!" or "Yes, you have reason to be proud of yourself!" Examples of validation were statements such as, "Yea, your belly's hurtin' and your breasts are hurtin' and everything's hurtin'" or "Yes, your 'super mom' image is tarnished" or "It makes you feel better, OK". A nurse-midwife was coded to be engaging in active listening when she interjected verbalizations of keeping on track with the client's conversation, such as frequent "uh huhs". Probing was distinguished from

clarification by the CNM actively trying to get more information on a certain subject. An example of probing was "why do you ask?" and of clarification was "You just woke up sweating, right?". An example of reassurance was "You can't spoil babies at this age - you're doing fine."

The visits were permeated with many incidents of humor coming from both the CNM and the client. In one interview, the CNM told the client that the time for resumption of sex was when "the body is ready, the head is ready, and the rubbers are ready" and referred to sex without intercourse as "outercourse". When individual analyses were compared, it was discovered that many of these new concepts had been similarly coded and defined by all four researchers. They came up with similar words independently to refer to the same phenomenon occurring in the visits. After considerable discussion, consensus was reached as to the conceptual and operational definitions of these new codes. Once the definitions were agreed upon, the transcripts were reanalyzed jointly by the researchers to accurately identify the frequency with which each new concept was present in the transcripts. Table 7 is a presentation of the new concepts which emerged along with their operational definitions and Table 8 is a

frequency distribution of these concepts among the visits.

The individual codes were then merged into three broader categories which appeared interrelated and interdependent: therapeutic techniques, lateral relationship, and empowerment. Conceptual definitions for each were arrived at following extensive discussion on the part of the researchers and review of relevant literature.

The category labelled therapeutic techniques was conceptually defined as: a process of communication which benefits/encourages growth and healing. The CNM facilitates the development of a trusting/honest relationship and thus encourages the client's sharing of self. The following codes were operational examples of this : active listening, probing, clarification, humor, non-judgmental attitude, encouragement, facilitation and permission-giving.

A lateral relationship between the CNM and client was defined conceptually as: The CNM promotes an interaction which is characterized by a sense of openness, mutual regard and equal footing as human beings and thus a sense of commonality between CNM and client. The code of alignment, when combined with the collective, subjective responses of the individual

Table 7

Definitions of Codes Identified in Analysis of Five Postpartum Visits

Code	Definition
Encouragement	The CNM shares with the client a sense that her situation is improving or has potential to improve.
Affirmation	A positive declaration by the CNM providing praise, credit and/or support; an emotive statement.
Validation	Confirmation by the CNM of a feeling/perception stated by the client.
Probing	The CNM uses open-ended questions/statements for the purpose of eliciting further information/revelations from the client.
Reassurance	Conveying a sense of well-being, healthy progress, normalcy.
Humor	A comical, witty or amusing exchange initiated by the CNM.
Clarification	CNM seeks to elucidate complete meaning of client's statement.
Active Listening	Verbal cues by the CNM which encourage the client to continue talking.
Alignment	The CNM demonstrates empathy, shared experiences, perceptions or feelings of mutuality with the client; alliance with client.

Table 8

Frequency of Identified Codes which were Collapsed into Major Concepts from Five Postpartum Visits

Concepts/Codes	Frequency of Occurrence
Therapeutic Techniques	
Encouragement	19
Probing	8
Clarification	16
Humor	28
Active Listening	16
Empowerment	
Affirmation	19
Validation	32
Reassurance	24
Empowerment	5
Lateral Relationship	
Alignment	12

researchers coded on the tool, eg. empathy and shared experiences, was seen to be conducive to and representative of a lateral relationship and formed the operational definition of this category.

Empowerment was conceptually defined as: the process of giving and/or receiving power, strength, and ego reinforcement. In the CNM/client relationship, empowerment occurs when the CNM, through her attitude and approach to care, enhances the client's inner strengths and resources, i.e., gives ownership of resources to the client. The empowering CNM recognizes the client's inner abilities and assists the client to become aware of them herself. The codes which were collapsed to form this concept were affirmation, validation, reassurance, and support.

One CNM's perception of the uniqueness of CNM postpartum care seemed particularly consistent with these new findings. Her responses were "A more personal relationship", "Warmer", "They (the clients) know I've been through it and I understand" and "Women feel free to call with 'silly things'". These statements seem to reflect a process component of care as identified in the analysis of the current data.

CHAPTER FOUR

DISCUSSION OF FINDINGS

Content

The purpose of this study was to identify the components of CNM postpartum care and to see if the framework developed by Lehrman was adaptable to the postpartum period. The findings of this study suggest that Lehrman's tool is essentially adaptable to the postpartum period. Although the results lend validity to the aspects of nurse-midwifery identified by Lehrman the data also suggest that some broadening of the definitions might be indicated for postpartum care. This possibility was seen particularly in relation to the aspects of education and counseling and continuity of care. It is difficult to determine whether this is a reflection of the difference in needs of antepartum and postpartum clients, a difference in philosophical approach of participating CNM's, or differences in coding between research groups given the inherent difficulty in replicating qualitative research.

In addition, it is unclear whether the issue of aspects overlapping occurred in Lehrman's study and how they were coded if they did occur. This was perhaps more problematic in the current study in which the aspects described by Lehrman were being measured in

terms of both occurrence and frequency rather than occurrence only. This can be explained by the slightly different purposes of the two studies. Lehrman's study used grounded theory to generate and validate emerging concepts. The current study was intended to test the adaptability of Lehrman's tool to the postpartum client and thus test the generalizability of Lehrman's conceptual framework to a different scope of nurse-midwifery care, i.e. postpartum care. Therefore, it was felt by these researchers relevant to measure frequency of occurrence of the eight aspects in order to assess the ability of these concepts to adequately describe aspects of CNM care of the postpartum client. Given this, the investigators of this study felt it reasonable to measure frequency of the aspects regardless of overlap.

Results of this study also suggest that the list of content components of care in the postpartum period adapted from the literature and Lehrman's prenatal tool was essentially comprehensive. A weakness in the list of expected components was that some items were too specific in their wording and at other times not specific enough. For example, signs and symptoms of involution is a very specific topic of discussion and as such did not allow for discussion of the nature and

pattern of lochia without reference to the process of involution. Thus, results of the analysis of these visits would suggest changing the wording for measurement of this component of content discussion.

In contrast, the topic of Concerns Discussed did not differentiate between those which were spontaneously expressed by the client and those which were elicited by the CNM. For this topic of discussion the tool was thus not specific enough. The researchers felt that future use of this tool should include this distinction because it may reflect a difference in the nature or components of CNM care.

The tool used for the purposes of this analysis included several aspects of the physical exam which were not found in analysis of the transcripts. Because the sample for this study is comprised of visits which were all conducted at approximately 2 weeks postpartum, the lack of a more complete physical exam may reflect an emphasis on the emotional rather than the physical adaptations of the client.

The one visit in which a thorough postpartum physical assessment was noted was for a client who had given birth at home. This may reflect the difference in practice setting in that this client would not have received the initial postpartum physical assessment and

teaching which one would expect during a hospitalization after delivery. On the other hand, the extensive physical exam may simply reflect a philosophical practice difference on the part of this CNM. In her questionnaire she indicated that this was a routine part of her postpartum visit. Ultimately, the sample size is too small to do more than speculate about an isolated difference.

The absence of any references to preparation for parenthood classes might be reason for deleting it from the postpartum tool. This change would, however, need to be supported by further research, as the small sample size limits the significance of such findings.

Although blood pressure and weight were recorded for each of the clients they were not included as topics discussed in any of the visits. However, the small sample size and the early timing of the visits would suggest that this topic remain on the measurement tool until further study. This would also apply to other topics not frequently discussed in the visits such as return of menses, laboratory tests and/or weight loss.

One somewhat unexpected finding in terms of topics discussed was the presence of relatively brief references to the labor and delivery experience in only

three out of the five interviews. Given the emphasis placed on this topic in the literature, it had been expected that this would have been found more consistently and discussed more extensively. This was particularly striking in light of the fact that four of the five clients had been assisted in delivery by the CNM conducting this first postpartum exam. It may be that discussion of the labor and delivery experience took place in the hospital before the client was discharged or at home during the first 24 hours and was no longer perceived to be a pressing need on the part of the client. However, the small sample size may not have been representative and further study would be needed before such an assumption could be made.

No new topics emerged during analysis of the transcripts but rather adaptations to existing components. However, the tool is believed by these researchers to be representative of the content components of CNM postpartum care.

Process

The findings of this study related to the process components of care appear to be potentially more significant in light of the new concepts identified. Lehrman's framework incorporated very broad elements to be representative of the process of CNM/client

interaction. Her report (Lehrman, 1981) unfortunately included only minimal explanations as to how these components were reflective of the process of care.

For instance, Lehrman stated that the presence of laughter, reassurance and social conversation were evidence of a "warm relationship and rapport between the client and the nurse-midwife" (Lehrman, 1981, p.36). Lehrman reported on the frequency with which the physical exam occurred between two distinct periods of conversation as well as the percentage of the visits in which the CNM talked more than the client, initiated more new subjects and asked more questions. She did not however indicate why or how she felt those interactions influenced or represented the process of care.

The concepts of therapeutic techniques, lateral relationship, and empowerment appeared to represent the nature of the relationship between the CNM and her client. Because this relationship reflects an approach to care and/or an attitude assumed by the CNMs, these new findings seem best defined as a process component of CNM care. This is not only consistent with Lehrman's conceptual framework but also helps to bring more specificity to the elements she noted that were

representative of the process of CNM/client interactions.

Elements of the codes and concepts which emerged in this study were alluded to in Lehrman's work. Participative Care incorporates the concept of joint assessment with the client and may thus contribute to the establishment of a Lateral Relationship. The subjective responses of the researchers in this study which included a sense of adaptability on the part of the CNM might represent a component of Flexibility of Care. The possible similarity with Consumer Advocacy has been previously discussed.

The distinction between the concepts presented here and those which were identified and defined by Lehrman appears to be twofold. Lehrman's findings emphasized that the aspects of nurse-midwifery practice are content components which direct the services provided by the CNM. The present findings have suggested that it is possible to weave these new, expanded concepts into a multi-dimensional process component of care.

It is felt that these concepts are mutually interactive and that an interrelationship between the three concepts exists, but there is enough uniqueness present to separate them. The relationship between the

three concepts did not appear to be linear. A schematic model representing the relationship of these three concepts was constructed in the form of a triangle (Figure 1).

The two-way arrows connecting the three points of the triangle signify the interconnectedness and reciprocity of concepts. For example, the establishment of a lateral relationship potentially strengthens the effectiveness of the therapeutic techniques employed. Likewise, the use of therapeutic techniques such as active listening, encouragement, clarification and so forth can be utilized in such a way as to build/strengthen a lateral rather than hierarchical relationship. Empowerment can be seen as a therapeutic technique or as enhancing a lateral relationship. The researchers interpreted the results of this study to imply that empowerment was also the desired goal of the use of therapeutic techniques and the building of a lateral relationship. Therefore, for the conceptual purposes of this study, it was placed at the apex of the triangle.

These aspects of process are not new concepts, although they may not have been previously identified as essential components of CNM care. They have been a part of psychotherapeutic literature for many years.

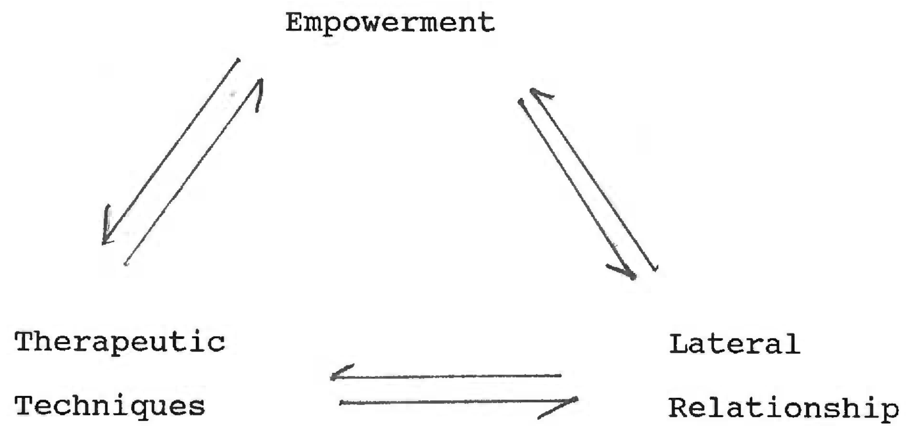
Figure 1. A schematic representation of the interrelation between concepts which emerged from analysis of five postpartum visits.

THE WITH-WOMAN MODEL OF

NURSE-MIDWIFE/CLIENT

INTERACTION:

A PROCESS COMPONENT OF CARE



The 1950's produced those who discussed therapeutic techniques, relationships, and alliance (Allport, 1954; Maslow 1954; Rogers, 1951; 1957, 1961, 1967; Sorokin, 1950). These individuals described a unique relationship between the therapist or care provider and the client that was essential to growth, change, and effective therapy.

Carl Rogers (1957) formulated three attitudinal conditions which he felt were "the necessary and sufficient conditions of therapy" (p.10-11). These were congruence between experience and behavior, empathy, and unconditional positive regard. The relationship that formed under these conditions has come to be called the therapeutic alliance (Brenner, 1979; Curtis, 1979). Other references have been made to this important bond and the facilitative/therapeutic interactions that create or emerge from this relationship (Forchuk & Brown, 1989: Lamandri, 1987; Poncar, 1989).

The establishment of a lateral relationship, or the "therapeutic relationship" mentioned above, may have a significant impact on the effectiveness of therapeutic techniques in any area of health care. Yalom (1980) felt it was the surreptitious "throw-ins", such as compassion, presence, caring, extending

oneself, touching the client at a profound level, that made the difference in effecting growth and healing. The lay midwifery literature has suggested this idea (Gaskin, 1978; James, 1988), but it has only been alluded to in the nurse-midwifery literature (Lehrman, 1981). Midwifery, meaning "with woman," is accepted as a profession that serves rather than controls the woman and her birthing energy. Emotional and spiritual support of the childbearing woman and her family are hallmarks of the care provided by midwives.

The conceptualization generated from the results of this study are supported in the sociologic, psychologic, midwifery and nursing literature. The codes which were collapsed to form these concepts were present in all of the visits. The consistency of this finding lends support to the validity of this conceptualization. These findings are particularly interesting considering that the CNMs participating in this study represented three separate practice settings that served a diverse group of clients.

The findings of this study suggest the possible presence of a dynamic and therapeutic relationship between the CNM and client which may facilitate the achievement of health through empowerment of the individual client. It would be premature to suggest

that this approach to care is unique to midwifery, as it may well be found as an important component of other health care professions. Clearly, the concept warrants further study.

CHAPTER FIVE

CONCLUSIONS

Study Summary

The identification of the components of care as provided by CNM's is essential to further understanding the contribution of the profession to the care of women and childbearing families. Lehrman (1981) was the first CNM researcher to address this issue in the literature and has proposed a framework which defines content and process components of care of the antepartum client. She further described eight aspects of CNM care which directed the services provided and developed a tool to measure the identified components. The purpose of this study was to describe postpartum care provided by CNM's using Lehrman's framework and to test the adaptability of her tool to the postpartum visit.

The sample consisted of five CNM's representing three different practice settings and their postpartum clients. The CNMs were providing full-scope midwifery care to a diverse population of women and their experience ranged from two to ten years in practice. All of the CNM's had provided some portion of their clients' antepartum care and four of the five had assisted the client during delivery.

Data were collected by means of audio-recordings of the client's first postpartum visit with her CNM and by a demographic questionnaire which was administered by one of the study investigators following the visit. The questionnaire for the CNM elicited demographic information as well as a description of typical postpartum services provided, time of first postpartum visit, and community resources utilized. In addition, an open-ended question asking the CNM to share her perception of what makes CNM care of the postpartum client unique was included. The client questionnaire also solicited demographic information, previous services provided by the CNM, prenatal education, and obstetrical and intrapartum history.

Lehrman's tool was adapted for use with the postpartum client based on a review of CNM literature of the past 20 years. The adapted tool was then used to analyze the tapes and their transcriptions.

The eight aspects of CNM care described by Lehrman were found consistently in the data, although operational definitions of two appeared to be too narrow to adequately measure their occurrence in the postpartum visit. Specific content listed in the tool was found to be reasonably comprehensive with minor revisions. Of the main topic areas measured, only one

(Client participation in parent education classes) was not supported by the data. However, no new topic areas emerged from the analysis.

In the analysis of the process component of care, the findings of this study suggest the possible presence of a dynamic and therapeutic relationship between the CNM and client which may facilitate the achievement of health through empowerment of the individual client. The conceptualization generated from the results of this study are supported in the sociologic, psychologic, midwifery and nursing literature. The codes which were collapsed to form these concepts were present in all of the visits. This seemed to also lend support to the validity of this conceptualization. These findings are particularly interesting considering that the CNMs participating in this study represented three separate practice settings and provided services to a diverse group of clients.

Limitations

There are a number of limitations with this study. The quantification of qualitative data is a difficult task as it requires concrete definitions of abstract concepts. Although the eight aspects of CNM care proposed by Lehrman were clearly defined, it was unclear how the more specific components on the

original tool were coded. Therefore, in conducting this study, decisions regarding coding dilemmas were resolved through discussion of the investigators. There may be some disparity between the way these dilemmas were resolved between the two studies, potentially altering the results.

Researcher bias may have influenced coding and the concepts generated. Although it was hoped that having four investigators independently code the data initially would reduce the potential impact of researcher bias, the surprising congruence of the codes derived independently is difficult to interpret. While it could represent the validity of the concepts ultimately identified, it could also be indicative of a shared philosophy of practice among the investigators. The significance of Lehrman's framework on practice and its impact on the philosophy of the profession were discussed extensively by the investigators prior to data collection. This intense interactive process may have contributed to a blending of personal philosophy in a group whose bias was already fairly similar.

Finally, while it did appear that saturation was achieved for both Lehrman's aspects of nurse-midwifery practice and the new process concepts that emerged, the sample size was too small to assess the

comprehensiveness of specific services provided and topics discussed.

Implications for Practice

In order to understand what it is that contributes to the improved outcomes seen in populations cared for by nurse-midwives, it is important to identify and understand the components of the care they provide. In addition, this understanding could help further the development of a theoretical understanding of the care provided by nurse-midwives. Such information is crucial to nurse-midwifery education in order to insure a consistent, high level of professional competence and expertise.

This study suggests the possible existence of a potentially powerful aspect of the components of CNM care that has not previously been identified in the nurse-midwifery literature. Although further investigation is needed, these concepts may prove to be a critical element of the unique contribution of nurse-midwifery to the care of women and childbearing families.

Recommendations for Future Research

Recommendations for further study include the need for additional testing and adaptation of the measurement tool. Diversity should be sought in the

educational background of participating CNM's, practice settings, clientele served, and timing of the visit in order to further assess the ability of the proposed concepts to comprehensively describe components of nurse-midwifery care.

Although Lehrman's research incorporated process as a significant component of CNM care, her research seems to emphasize content, particularly the eight aspects of nurse-midwifery practice. Results from this study suggest that process as operationalized by Lehrman may not totally representative of the attitudes/approaches to care. Therefore, research designed to further explore process concepts such as those identified in this study might help clarify its potential effect on the outcomes of CNM care.

Additional research is also warranted in ascertaining whether and to what degree practice settings, environmental pressures, and/or clientele served have an impact on the components of care provided. While CNM's may ascribe to a certain philosophy of care, these issues may have a significant impact on the services actually provided.

Finally, further research is needed to identify and compare the components of CNM care as described by Lehrman and as proposed by this study to components of

care as provided by physicians and other care providers. With that data, it might then be possible to determine which components are unique to CNM care and therefore potentially contributory to the improved outcomes that have been consistently reported in the literature.

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APPENDICES

APPENDIX A

Components of Prenatal Care Measurement Instrument
Part I: CONTENT

<u>Aspects of Nurse-Midwifery Care</u>
Continuity of Care
Education and Counseling as Part of Care
Noninterventionist Care
Flexibility of Care
Participative Care
Consumer Advocacy
Time
Family Centered Care

<u>Physical Exam</u>
BP
Weight
Fetal Heart Rate
Uterus measured/palpated
Legs checked for edema
Diet history taken
Urine checked for glucose and protein
Blood drawn
Other

<u>Client Participation in Childbirth Education Classes</u>
Client has completed classes
Client is attending classes
Client is planning to attend classes
Client has attended/is/will be attending classes and is reading
Client does not plan to attend classes but is reading
Client does not plan to attend classes and does not indicate reading
No information on the tape to judge

<u>Topics Discussed</u>
Health Status
- Pregnancy progress/Interim history
- Danger signs
- Exercise/Rest
- Explain illness
- Signs/symptoms of labor
- Discomforts of pregnancy
- Laboratory tests/results
- Nutrition/diet history
- Breast Care
- Weight gain/Weight loss

BP/Vital signs
Emotions of pregnancy
Other

Preventive Health Care
Accident prevention
Dental Care
Family planning
Community health resources
Smoking
Ultrasound
Other

Treatments
Vitamins
Other medications
Other

Preparation for Labor
Conduct of labor and delivery
Alternate birth options/Orientation
Prenatal education classes
Reading by client
Cesarean section
Job/employment after birth
Explaining CNM role
Other

Preparation for Parenthood
Breast feeding
Infant care
Rooming-in
Pediatrician
Circumcision
Attitudes toward pregnancy/parenting
Other

Miscellaneous
Charting/paperwork
Hospital admission procedures
Other

PART II: PROCESS

Process

Talking by CNM
Talking by client
Talking by significant other
Silence (lack of talking). Reasons____
CNM asking question. Number asked_____
Client asking questions. Number asked____
Significant other asking questions. Number asked___
Social conversation by CNM
Social conversation by client
Social conversation by significant other

Unable to understand details of the conversation
Interruptions Type___

Initiation of Subjects

New subjects introduced by CNM
New subjects introduced by client
New subjects introduced by significant other
Question by client not answered by CNM
CNM asks if client has any questions

Emotional Tone of the Visit

Incidents of laughter
Incidents of crying
Incidents of reassurance by CNM
Incidents of authoritarianism by CNM

General Order of the Visit

Talking/exam without talking/talking
Talking/exam with talking/talking
Talking/exam without talking
Exam without talking/talking
Exam with talking/talking
Exam with talking

The evaluator's subjective reaction to the visit

Appendix B

ASPECTS OF NURSE-MIDWIFERY CARE:
CONCEPTUAL AND OPERATIONAL DEFINITIONS

Continuity of Care

Conceptual Definition: The provision of health care which conforms in the past, present, and future to the individual client's needs.

Operational Definition: The occurrence on the client demographic sheet of past services provided or future services to be provided to this client; or, at least one reference to past care or one plan for future care during taped visit between client and CNM.

Family Centered Care

Conceptual Definition: The delivery of safe quality health care while recognizing, focusing on, and adapting to the needs of the client-patient, her family, and her newborn.

Operational Definition: During the taped visit, the mention by the CNM of any one of the following: family, significant other, husband, partner, or financial arrangements of the client; or, a significant other is present and participates in the visit.

Education and Counseling as Part of Care

Conceptual Definition: The provision to the client of new knowledge and guidance from the health care provider.

Operational Definition: The occurrence of at least one 1-minute period, which is continuous, during which the CNM discusses one subject with the client for the purpose of teaching, counseling, or instructing.

Noninterventionist Care

Conceptual Definition: The ability of the health care provider to focus on the maintenance of health and the physiologic normalcy of childbirth, and the promotion of increased levels of health by the use of natural techniques.

Operational Definition: The occurrence of at least one incident on the tape where the CNM offers a non-medication treatment for a client's complaint or for her health promotion.

Participative Care

Conceptual Definition: The joint assessment, evaluation, and planning of a program of management for the client by the client and the health care provider.

Operational Definition: The occurrence, during the taped visit, of a least one incident of mutual collaboration on a matter between the CNM and client to reach a decision or conclusion; or, the occurrence of one instance where the client is involved in and/or takes responsibility for a portion of her health care during the visit.

Consumer Advocacy

Conceptual Definition: The ability of the health care provider to direct, support, and encourage the client's participation in health.

Operational Definition: The occurrence, during the taped visit, of at least one incidence where the CNM provided encouragement, emotional support, or positive feedback to the client regarding the client's decision in her own health care or that of her newborn.

Time

Conceptual Definition: The subjective feeling that the health care provider is unhurried and will vary the period of interaction according to the client's needs.

Operational Definition: The duration, measured in minutes and seconds, of the audible encounter between the client and CNM which is recorded on the audio tape.

Flexibility

Conceptual Definition: The ability of the health care provider to vary her/his methods in the provision of health care.

Operational Definition: The CNM indicates possible alternatives to meet the client's needs.

APPENDIX C

Oregon Health Sciences University
School of Nursing
Master's Research Project

Certified Nurse-Midwife Questionnaire

I. Practice Demographics

A. Type of Practice

________Private: CNM group/solo practice
________Private: CNM and MD joint practice
________Hospital based group practice
________Employee (please circle the appropriate response: State, county or municipal clinic; physician; hospital; other

B. Site of practice (Please indicate if more than one practice site applies)

_______Hospital
_______Birth Center
_______Clinic (public, private, other)
_______Client's home
_______Other: please explain_______________
____

Comments ___________________________________
____

C. Scope of Practice:
Please circle the midwifery services you provide on a regular basis: antepartal, intrapartal, postpartal, interconceptional, family planning, newborn, prescriptive privileges, other________________________

II. Personal Demographics

Age _____ Sex ____ Degrees held _____
Years in practice ____

III. Postpartum Services Offered by You or Your Practice

A. Follow-up Visits

_____ 2 week visit ____ 4 week visit
____ 6 week visit ____ Home visit
____ Postpartum counseling for infant feeding
____ Parenting classes ____ Other (please explain)______________________
____

B. Nature of visit: (please circle) with infant, with partner, with family.

C. Please provide a brief description of your routine postpartum follow-up care: ________
____

D. Community resources to which you refer your clients

____ Counseling/support services for infant feeding

____ Postpartum support groups
____ Postpartum exercise classes
____ Parenting classes
____ Infant care classes
____ Home care services (nursing, housekeeping, etc.)
____ Other: ______________________________

IV. (optional) Please share your perception of what makes CNM care of the postpartum client unique. (use back of page if necessary)

APPENDIX D

Oregon Health Sciences University
School of Nursing
Master's Research Project
Client Questionnaire

I. Demographic Information
Age ____
Marital Status M S LW D W
Race ____
Years of Education ____
Prenatal Education ____
Prenatal preparation for postpartum transitions

II. Obstetrical history (for most recent pregnancy)
Gravida ____ Para ____
Number of prenatal visits ____
Significant AP or IP complications ____________
Significant PP complications (for mother or baby) ____

III. Hospital Births
Did complication lengthen hospital stay? yes/no
Was mother discharged before baby? yes/no
Was baby discharged before mother? yes/no

IV. Out-of-Hospital Births
Did complications result in transfer to hospital? yes/no
If yes, who was transferred? mother/baby/both
Length of hospital stay: Mother - 1 day 2 days 3 days >3
Baby - 1 day 2 days 3 days >3

APPENDIX E

Oregon Health Sciences University
School of Nursing
Informed Consent

As a Certified Nurse-Midwife providing postpartum care you have been selected to participate in a study examining CNM's and postpartum care. The study is being conducted by Melanie Kohl, R.N., Ann Morten, R.N., Prairie O'Mahoney, R.N., and Catherine Pelosi, R.N., students in the Masters Program, Department of Family Nursing.

The purpose of this study is to adapt a measurement tool first developed by Ela Joy Lehrman, R.N., C.N.M., M.S.N. which identified the components of prenatal care as provided by nurse-midwives.

The information will be extracted from audio-taped visits of clients to the midwife in the postpartum period. If you consent to participate, your visit with your client will be taped. The tape will be reviewed by the four students involved in this project and the elements of the interactions during the visit will be recorded. The information will be coded by number and made accessible only to the four named researchers to protect your anonymity. The tapes will be destroyed after completion of the project.

You may refuse to participate in the study and you are free to withdraw your consent and discontinue participation at any time without jeopardizing your relationship with the researchers or with Oregon Health Sciences University.

Any of the project staff would be glad to answer questions you may have about the study. They may be reached through the secretary at 279-8383.

Please check one:

____ I have read the foregoing and agree to participate in this study.

____ I choose not to participate in this study.

______________________________ Signature   ________________ Date

APPENDIX F

Oregon Health Sciences University
School of Nursing
Informed Consent

As a client seeking postpartum care from a Certified Nurse-Midwife you have been selected as a prospective participant in a student nurse-midwife study. The study is being conducted by Melanie Kohl, R.N., Ann Morten, R.N., Prairie O'Mahoney, R.N., and Catherine Pelosi, R.N., students in the Masters Program, Department of Family Nursing.

The purpose of this study is to describe how Certified Nurse-Midwives provide postpartum care. If you consent to participate, your postpartum visit will be taped. The tape will be analyzed to see what types of things the Certified Nurse-Midwife says and does, not what the patient does. The tape will first be listened to by the students conducting this study and any identifying information such as names, addresses, etc., will be deleted. The tape will then be written down on paper to make it easier to analyze what the midwife says. The tape and the written down copy of the visit will be destroyed after completion of this project. Also, if you agree to participate in this study, certain information from you and your medical record would be asked such as your age, educational background and marital status. You may see a sheet listing the types of information we would want before you agree to be in the study. The purpose of getting this type of information is to generally describe the patients who participated in the study.

You may refuse to participate in the study and you are free to withdraw your consent and discontinue participation at any time without jeopardizing your relationship with your midwife or with Oregon Health Sciences University.

Any of the project staff would be glad to answer questions you may have about the study. They may be reached through the secretary at 279-8383.

Please check one:

____I have read the foregoing and agree to participate in this study.

____I choose <u>not</u> to participate in this study.

____________________________ ________________
Signature Date

APPENDIX G

Chart Review Form

Vital signs: ___BP ___T ___P ___R ___Wt.

Narrative note: ___

Physical exam: __Breasts __Abd. __Perineum

__Speculum __Pap

Labs ordered: __ Reviewed in note: __

Rx ordered: __

Referrals noted: __

RTC noted: __

Comments:

APPENDIX H

Components of Postpartum Care Measurement Instrument
Part One: Content

Aspects of Nurse-Midwifery Practice

Continuity of care
Education and counseling as part of care
Noninterventionist care
Flexibility in care
Participative care
Consumer advocacy
Time
Family centered care

Physical Examination

Blood pressure
Weight
Breast exam
Abdominal exam
Perineum
Speculum exam
Pap
Birth control method (Diaphram, IUD)
Other

Client Participation in Parent Education Classes

Client has completed classes
Client is attending classes
Client is planning to attend classes and is reading
Client does not plan classes but is reading
Client does not plan classes and is not reading
No information on tape to judge

Topics Discussed: Health Status

Interim history
Danger signs
Exercise and rest
Explain illness
Signs and symptoms of involution/subinvolution
Return of menses
Discomforts of postpartum/relief measures
Laboratory tests/results
Nutrition/diet history
Breast care
Weight loss
Blood pressure/vital signs
Emotions/depression/"blues"
Concerns: Self
Infant
Others
Sexuality/contraception
Other

Anticipatory Guidance

Self
Infant (Breast feeding, behavior, care)
Other

Treatments

Vitamins/iron
Other medications (RhoGam)
Other

Adaptation to Parenthood

Labor and delivery experience
Feelings towards baby
Family adjustments/interactions
Support system
Stressors
Coping strategies

Miscellaneous

Charting/paperwork
Return to clinic/follow up
Referrals

Part II: Process

Process

Talking by CNM
Talking by client
Talking by significant other
Silence (lack of talking) Reasons -
CNM asking questions. Number -
Client asking questions. Number -
Significant other asking questions. Number -
Social conversation by CNM
Social conversation by client
Social conversation by significant other unable to understand details of conversation
Interruptions. Type -

Initiation of Subjects

New subjects introduced by CNM
New subjects introduced by client
New subjects introduced by significant other
Question by client not answered by CNM
CNM asks if client has any questions

Emotional tone of Visit

Incidents of laughter
Incidents of crying

Incidents of reassurance by CNM
Incidents of authoritarianism by CNM

General Order of Visit

Talking/exam without talking/talking
Talking/exam with talking/talking
Talking/exam without talking
Talking/exam with talking
Exam without talking/talking
Exam with talking/talking
Exam with talking

Evaluator's Subjective Reaction to Visit

ABSTRACT

This research project was a descriptive, exploratory study of CNM care of the postpartum client. The conceptual framework for this study was based on research conducted by Lehrman (1981) identifying the content and process components of CNM care of the antepartum client. A tool developed by Lehrman for measurement of these components of care was adapted for use in this study. The following research questions guided this study: (1) What are the components of CNM postpartum care? and (2) Can these components be adequately identified using Lehrman's framework? The study sample consisted of five consenting CNMs who met the study criteria and represented three separate nurse-midwifery services. Postpartum clients were solicited by the researchers for participation in the study at the time of their regularly scheduled clinic visit. Informed consent was obtained from all participants (See Appendices E & F). Data were collected by audio-recordings of visits between CNM and client, chart review for additional content, and demographic questionnaires developed by the researchers and administered to both clients and CNMs following the visit (See Appendices C, D, & G). The adapted tool for measurement of components of care (See Appendix H) was

used to analyze the data collected. Analysis suggested that the adpated tool identified the content components of CNM care of the postpartum client and that the aspects of nurse-midwifery care of the prenatal client as defined by Lehrman were also present in the postpartum period. The process components of CNM care developed by Lehrman were also identified in the postpartum visits analyzed for this study. Coding and analysis of qualitative data not well measured by the adapted tool suggested the possible presence of a dynamic and therapeutic relationship between the CNM and client which might also represent a process component of care. This paper included a discussion of these additional findings and presented a schematic representation of the possible interrelationship between the newly defined concepts.