4-27-1970

# The nurse-midwife in the midwest: A study of factors that affect her utilization

Gwen Marie Ohlendorf
*Illinois Wesleyan University*

# THE NURSE-MIDWIFE IN THE MIDWEST

## A Study of Factors that Affect Her Utilization



Gwen Marie Ohlendorf

Submitted for Honors Work
In the Department of Nursing
Illinois Wesleyan University
Bloomington, Illinois
1970

Accepted by the Department of Nursing of Illinois Wesleyan University in fulfillment of the requirement for departmental honors.

April 21, 1970
Date

Jane M. Gordon
Project Adviser

April 27, 1970
Date

Wayne W. Westland
Out-of-Department Adviser

Date

Mary D. Shamp
Department Head

April 27, 1970
Date

Winfred P. Peden
Academic Adviser

# PREFACE

My primary purpose for undertaking this project was to be able to receive departmental honors from the school of nursing at Illinois Wesleyan University. My second purpose was to be able to choose a topic in the area of maternal-child nursing which is of particular interest to me and investigate it in depth.

I can truly say this has been a unique experience for me and I have learned much from the entire endeavor. I have received excellent help and guidance from my project advisor, academic advisor, out-of-department reader, and department head. I have also received much needed reassurance, support, and assistance from my family. To all these people I owe a great deal of thanks in helping me present this paper.

TABLE OF CONTENTS

LIST OF TABLES

# INTRODUCTION

1. She shall help rich and poor alike.

2. She shall make sure that the mother names the true father.

3. She shall insure that the child be not murdered, maimed, or exposed to other perils.

4. She shall refrain from witchcraft, sorcery, unlawful prayer or abortifacients.

5. She shall not destroy professional confidences.

6. She shall not demand an unusual fee.[1]

This is the Midwives Oath of 1649. The graduates of today's programs are a far cry from the old-fashioned "granny" midwives whose inadequate knowledge of obstetrical techniques or even simple hygiene resulted in American's misunderstanding the word "midwife" for almost three generations.[2] Yet, this oath was an attempt to promise what was considered at that time to be a high caliber of service. The nurse who enters nurse-midwifery in the twentieth century must have strong convictions that she is willing to face

---

[1]Neville R. Butler, "Role of the Midwife in Meeting Problems," in The Training and Responsibilities of the Midwife, (New York: Josiah Macy Jr. Foundation, 1967), pp. 201-202.

[2]Dorothy Crane Davis and Lamor Middleton, "Rebirth of the Midwife," Today's Health, February 1968, p. 28.

the possibility of lowering status and to put up with all kinds of critical comments.[3] Vera Keane states that in her opinion nurses enter midwifery for the following reasons: 1) This woman has a sort of divine dissatisfaction with maternity nursing as it is practiced today, and 2) she feels clinical nursing requires a special level of knowledge equivalent to the kind of preparation that one must have as a nurse or doctor, to teach.[4] A nurse-midwife must be a nurse first; she needs the background of basic professional nursing upon which to build the additional knowledge and skills of nursing to which she has incorporated and integrated the special skills of midwifery.[5]

In 1912, the Congress of the United States became aware of the special needs of children and established the Children's Bureau. The first act by the bureau was to study infant deaths. From this study it became evident infant health was inseparable from maternal health and the quality of maternity care has a direct bearing on death occurring during the first month after birth.[6] This was the initial step to the development of better prenatal care, hospital delivery by a physician, and post-partal follow-up. In 1918, the Maternity Center Association was established in New York. Its main objective was to encourage women to seek prenatal care and to develop easily accessible centers where they could obtain it. As

---

[3]Vera Keane, "The Role of the Nurse-Midwife in the United States Today," in The Midwife in the United States, (New York: Josiah Macy Jr. Foundation, 1968), p. 97.

[4]Ibid., pp. 98-99. [5]Ibid., p. 91.

[6]Hazel Corbin, "Historical Development of Nurse-Midwifery and Present Trends," Bulletin of the American College of Nurse-Midwifery, March, 1959, p. 14.

a result professional nurses began to be drawn into the care of maternity patients, but their education failed to keep pace with their growing involvement.[7] What resulted was the education of nurse-midwives to help keep obstetric care on a high level.

Until about five years ago, the socio-economic structure of our country was such that the demand for nurse-midwives to function as they did in the early 1900's in the actual delivery of an infant remained low. Over the years, our socio-economic structure has changed and health manpower in the field of maternity has altered. Now many believe a nurse-midwife staff with a strong commitment to patient care provides better integrated and more consecutive care, combatting fragmentation which has been a problem for all those dedicated to maternity care services.[8]

In this country one will find the nurse-midwife functioning as a clinical nurse specialist within the framework of existing health organizations particularly in departments of obstetrics and gynecology and with medical consultation always available.[9]

The goal of nurse-midwifery has been defined as:

> . . . the provision of such care for the women of the country that their pregnancies would be wanted and planned, and would be supervised in such a way as to foster the unity of their homes, reduce to a minimum the incidence of scars on body or mind, and ensure as far as humanly possible that the infant would be healthy and unimpaired during the process of pregnancy and birth.[10]

---

[7] Ibid., p. 15.

[8] Keane, The Midwife in the United States, pp. 89-90. [9] Ibid., p. 89.

[10] John Stallworthy, "Changes in Midwifery--Progress or Regression," Nursing Mirror, February 7, 1969, pp. 34-35.

This paper will deal with the utilization of the nurse-midwife's skills in the midwest. The following sections will discuss the areas of health manpower and reactions to the nurse-midwife by other people, both of which have direct bearing on her present utilization.

## THE HEALTH MANPOWER PICTURE TODAY

It is almost trite to refer to the stunning growth of our population and the related expansion of our economy. Not only are there many more Americans for whom health services are to be provided, but many of these fall into the category of the very young and old who require the greatest amount of medical services. The increasing rise in the levels of education and personal income have not only made people aware of what health services are available but also have resulted in their making effective demands for these services.[11] Improved transportation, urbanization, private and governmental health insurance programs, and the increasing effectiveness of therapeutic procedures only serve to accentuate demands. It becomes obvious that if health care needs are to be maintained and adequately met there must be properly trained and educated suppliers of these services. They must be available in sufficient numbers and working in situations where necessary equipment and facilities are available and the services they provide must be efficient, effective, and rendered at a reasonable cost to the public.[12]

---

[11]Dwight L. Wilbur, "The Nation's Health Manpower," cited in Papers from the First National Congress on Socio-economics of Health Care, Chicago, Illinois January 22-23, 1967, (Chicago, Illinois: Council on Medical Service and the Division of Socio-economic Activities of the American Medical Association, 1967), p. 26.

[12]Ibid.

Health programs are "people at work" who are skilled but must first be produced by training and education. To continue the escalation of new health programs in the face of existing health manpower shortages is unrealistic.[13] However, we not only need more health workers, but we need good ones. They must be trained by well-prepared teachers and within the health complex of which they will become part. Inter-relationships and inter-dependence of one skill on the next are necessary to provide the best possible care and must be an important part of the training process.[14]

The manpower shortage is also aggravated by maldistribution. There are grave problems in the cores of major cities and severe deficits in the rural areas of the nation. The minority groups in the cities though not affluential, collectively become politically influential. In states with deficits in rural health services the state legislatures are often dominated by rural legislators. In both instances there can be found a latent resentment to medicine. This hostility can only be resolved through the development of responsible health programs designed to effectively meet their obvious needs.[15]

Today there are approximately four million births per year in the United States. It has been estimated that if every baby was delivered by a physician, each doctor would have to handle at least three hundred deliveries per year at the present population level.

---

[13]James L. Dennis, Ibid., p. 17.

[14]Dwight L. Wilbur, Ibid., p. 28.

[15]James L. Dennis, Ibid., p. 17.

Even if twenty to thirty percent of the deliveries are performed by residents and medical students the overload is still very apparent.[16] The rapid increase in child population since 1940 has not been matched by a comparable increase in obstetricians, pediatricians, and general practitioners. Also a large number of young women who were products of the post-World War II baby boom are now entering childbearing years. It is difficult to predict what their reproductive habits will be.[17]

According to the American Medical Association there are more than 16,000 listed physicians who are limiting their practice to Obstetrics and Gynecology. Of these only 8,000 are board qualified obstetricians and about 2,800 are residents. This leaves approximately 6,000 self-designated obstetricians who are either untrained, partially trained, poorly trained or waiting to take boards.[18] Thus the problem is not so much the lack of training programs, but the need to maintain a high level of quality in training and to attract a higher percentage of high ranking medical school graduates into obstetrics. Also, those physicians already in practice should have supplementary training to enable them to become fully qualified. Since the obstetrician-gynecologist is often the first person a young woman sees in a doctor-patient relationship he may have a great influence on her future and that of her children.[19]

---

[16]U.S. Department of Health, Education and Welfare, A report of five conferences held during 1967, Optimal Health Care of Mothers and Children: a National Priority, (National Institutes of Health publication, 1967), p. 33.

[17]Ibid. [18]Ibid.

[19]Ibid., p. 34.

To summarize, participants in a series of five conferences on "Optimal Health Care for Mothers and Children" concluded that if optimal health is to be a reality the focus must first be on service needs, secondly on the distribution and redistribution of the services and manpower already in existence, and then on what needs to be done about additional manpower needs.[20]

Today the physician is finding himself in the role of manager which is new to his tradition and for which he has not been specifically trained, but has nevertheless resulted from increasing social demands and scientific advances. As this managerial function increases so does the doctor's dependence on others. Thus it becomes essential for each member of this team to perform to specifications and make sure these skills interlock with others. As a result the physician becomes intensely interested in the caliber of training these supportive personnel receive. Their competence plays a vital part in his activities, and as medicine advances this dependency will increase.[21]

The relationship which generally develops between the obstetrician or gynecologist and his patient is an intensely personal one. Will this physician be willing to accept the changes that are occuring in his role and share his responsibilities with other members of the health team? This acceptance will depend upon the location of the medical services. In areas of no shortage of medical manpower and the people can afford to pay for the kind of care they expect there may be

---

[20] Ibid., p. 38.

[21] Wilbur, "The Nation's Health Manpower," p. 27.

reluctance to change. In regions where physicians are overworked and services do not meet the needs of the population, this change may be accepted with relief by both the physicians and patients.[22]

An estimate of 4.5 million babies are expected to be born in 1970 and including the new specialists in obstetrics this would result in two hundred and fifty-five deliveries for each obstetrician. In terms of prenatal care, complications, and post-partal follow-up this is still too many for adequate supervision.[23] A study done by I. M. Morriyama and S. Shapiro showed:

> An increasing number of countries have been experiencing lower infant mortality rates than the United States. Also the gap between the rate for the United States and the figures for countries with the most favorable experiences has widened.[24]

The decrease in the rate for the United States between 1954 and 1963 was 5.3 percent, this being far less than comparable decreases for the other areas studied.[25] Engel recently estimated that if American services were of equal quality all over the nation as those provided by Sweden and the Netherlands 40,000 infants would be saved yearly, because infant mortality in the first year of life occurred mainly in the first week.[26] Unless current knowledge and manpower resources are

---

[22]U.S. Department of Health, Education, and Welfare, Optimal Health Care of Mothers and Children: a National Priority, p. 41.

[23]John L. Greene, "The Nurse-Midwife," in Papers from the First National Congress on Socio-economics of Health Care, p. 115.

[24]Mary A. McCarthy, "Infants, Fetal and Maternal Mortality," in U.S. 1963 Vital and Health Statistics--Data from the National Vital Statistics System Series 20, (U.S. Department of Health, Education, and Welfare Public Health Service, September 1966), p. 5.

[25]Ibid., p. 7.

[26]John L. Greene, "The Nurse-Midwife," p. 116.

more effectively utilized the situation is expected to worsen, for even with the unexpected decline in birthrate there will still be an increasing number of expectant women needing health supervision. In the 1970's a twenty-five percent increase of women of childbearing age is expected.[27]

> The nurse-midwife will, I believe, prove to be the most sympathetic, the most economical, and the most efficient agent in the care of normal confinements.[28]

This statement was made by Fred J. Taussig in The Nurse Midwife more than fifty years ago. Today nurse-midwifery stands on the threshold of developing and fulfilling those words.[29]

Thus the practice of nurse-midwifery is nothing "new" on the American scene but its formalization as a profession makes it seem new. The nurse-midwife's purpose is not an emergency worker used to fill a void left by unavailable personnel nor an obstetrical technician who acts as an extra pair of hands and feet so physicians can accomodate more people. Her purpose is to provide the best possible nursing care for families having a baby.[30]

The nurse-midwife is admirably fitted to carry out normal prenatal care after the initial medical examination early in the preg-

---

[27]Lillian Runnerstrom, "Nurse-Midwifery at the Crossroads," Bulletin of the American College of Nurse-Midwifery, November, 1967, p. 119.

[28]David Harris, "The Development of Nurse-Midwifery in New York City," Bulletin of American College of Nurse-Midwifery, February, 1969, p. 11, cited in Sister M. Theophane Shoemaker, History of Nurse-Midwifery in the United States, (Washington D.C.: Catholic University Press, 1947), p. 8-9.

[29]Ibid., pp. 11-12.

[30]Vera Keane, "Where Are We Going?," Bulletin of the American College of Nurse-Midwifery, Spring, 1965, p. 2.

nancy. She is well trained to diagnose normal and abnormal pregnancy and take the proper steps based on this decision. She can provide systematic and regular examinations and record the results of the routine tests. It has been found that nurse-midwives do a better job of record keeping than many doctors. The nurse-midwife is available for questions regarding diet, nutrition, social difficulties and type of employment. Psychoprophylaxis and preparation for lactation are also found within this midwife's scope.[31] The average physician is aware that something more than physical care is required but often does not have the time or knowledge to provide these intangibles for a happy pregnancy.[32] The nurse-midwife can meet the pregnant woman's physical and emotional needs during labor and conduct a normal delivery or obtain the needed help if an emergency should arise. Then during the post-partal visit she can introduce family planning.[33]

A study was made to explore the possibility that there might be some changes in the concepts of maternity nurses after they had received a nurse-midwifery education and if there was any value in this training. The results emphasized that the respondents felt they had obtained an increased depth of knowledge and broader ideas than they had previously held. This assisted them in further developing their skills in maternity nursing and gave them greater confidence in their performance in caring for the pregnant family. Continuity of care and total patient care was stressed during the maternity cycle.

---

[31]Butler, The Training and Responsibilities of the Midwife, pp. 203-204.

[32]Jere B. Faison, "The Obstetrician and the Nurse-Midwife," Bulletin of the American College of Nurse-Midwifery, March 1959, p. 9.

[33]Butler, The Training and Responsibilities of the Midwife, p. 204.

The philosophy of nurse-midwifery and the type of maternity care that could be given as a result of this training provided the stimulus for some of the respondents entrance into nurse-midwifery.[34] Pregnancy was viewed as a normal physiological process and recognition of abnormalities was quicker as a result of the increased skill and knowledge. More responsibility and leadership roles resulted for many of the respondents but this was gained through education and broadened skill and knowledge of the whole maternity cycle. Thus, it was concluded that improvement in maternity care should continue as the leadership positions are filled and increased by more nurse-midwives.[35]

In an article called "Rebirth of the Midwife" by Dorothy Crane Davis and Lamor Middleton,

have compelled her to re-examine her thinking about midwifery.

> Our most critical problem is medical manpower and we cannot continue to ignore the solution offered by well-trained, medically supervised nurse-midwives in prenatal-care clinics and hospitals. It is obvious that we must rethink outdated positions.[36]

Dr. Hellman of Kings County Hospital in Hew York states:

> The efficiency of the nurse-midwifery service particularly its acceptance by the patients, is reflected in the 30% increase in the number of post-partum visits. Most important for effective family planning among the indigent are the time and empathy that nurse-midwives devote to their task. Physicians cannot afford to spend their time on these admittedly vital services.[37]

---

[34]May Petty, "Maternity Nursing Concepts Reported by Nurse-Midwives," Bulletin of the American College of Nurse-Midwifery, August 1967, pp. 83-87,

[35]Ibid., pp. 86-88.

[36]Davis and Middleton, "Rebirth of the Midwife," p. 32.

[37]Louis M. Hellman, "Nurse-midwifery in the United States," Journal of Obstetrics and Gynecology, December, 1967, p. 888.

He concludes that nurse-midwifery is a solution that deserves careful testing by obstetricians who are the specialists that determine the quality of maternity care throughout the United States.[38]

It is true that the certified nurse-midwife assumes many of the functions of the physician in regard to the medically uncomplicated patient, yet the ultimate responsibility lies with the medical staff. The nurse-midwife also does not assume the responsibility of the nursing care of the patient, as this falls within the realm of nursing services so as a result, the patient benefits more fully from the existing maternal and newborn programs.[39]

## REACTIONS FROM INDIVIDUALS ASSOCIATED WITH THE NURSE-MIDWIFE

Nurse-midwifery has not had a smooth development and there is still no consensus regarding its ultimate value or practicality in filling the growing needs in maternity care. Opposition to this developing profession can be found in both the field of obstetrics and nursing however, organized medicine and nursing are beginning to accept the development of nurse-midwifery in the United States as part of the future, and have displayed increasing willingness to discuss the problems that need to be solved.[40] In the following paragraphs a summary of the major areas of resistance raised against nurse-midwifery will be presented.

---

[38] Ibid.

[39] Dorothea M. Lang, "Providing Care Through a Nurse-midwifery Service Program," The Nursing Clinics of North America, (Philadelphia: W.B. Saunders Co., September, 1969), p. 512.

[40] Hellman, The Training and Responsibilities of the Midwife, pp. 154-155.

The nursing profession did not greet the advent of nurse-midwifery with enthusiasm. The nurse-midwife was frequently considered a threat to the financial security and the status of nursing. Also from the standpoint of nursing the nurse-midwife was engaged in the practice of medicine which has always been eschewed by nursing.[41] It was further pointed out to nurse-midwives there was no standardization of nurse-midwifery schools, and no philosophy or objective to act as a guide in the educational activities of the institution of learning. It was noted the functions of the practitioner has not been clearly described and no criterion for evaluation of the programs or the products of the programs had been formulated.[42] The carrying out of orders prescribed by a nurse-midwife has also proven to be an area of misunderstanding by the maternity nurse.[43] Another large objection to the development of nurse-midwifery by the nursing profession is, why should a profession, who is short of personnel, entice personnel from another profession which is even more shorthanded.[44]

However, Adaline P. Satterthwaite who was present at a Macy Conference held in Lake Como, Italy in 1966, felt a valuable team could be made of the public health nurse and nurse-midwife in mother's classes, diagnostic testing, family histories and home visiting. She also advocated the use of the practical nurse in the performance of routine procedures such as the sterilization of

---

[41] Ibid., p. 154.

[42] Rummerstrom, "Nurse-Midwifery at the Crossroads," p. 120.

[43] Lang, The Nursing Clinics of North America, p. 520.

[44] Greene, "The Nurse-Midwife," p. 116.

instruments and preparation of supplies that had been done by nurse-midwives. She emphasized the importance of teamwork. She felt the midwife should be the coordinator and the leader of the nursing team.[45]

The nursing profession has challenged nurse-midwifery and this emerging profession must take steps in the development of legislation to govern, standardize and regulate its practice.[46] They must also encourage more nurse-midwives to engage in teaching and systematically recording the functions of a nurse-midwife as they are performed, taught, and how they measure up to the expectations of other professional groups.[47] Progress had been made in all of these areas, but the task had just begun.

Physicians have presented many viewpoints of the nurse-midwife. She has been seen as a threat to the medical profession while others are over protective of her. Resistance has developed from the fact she is a female with less education than a physician. They do not realize the nurse-midwife is a registered nurse with extensive training and clinical backgroundin obstetrics.[48] Interns and new residents who have never worked with a nurse-midwife before may initially see her as their technical assistant.[49] Dr. Louis Hellman

---

[45]Satterthwaite, The Training and Responsibilities of the Midwife, pp. 215-217.

[46]Rummerstrom, "Nurse-Midwifery at the Crossroads," pp. 121-122.

[47]Keane, The Midwife in the United States, p. 86.

[48]Ibid., p. 87.

[49]Lang, The Nursing Clinics of North America, p. 519.

stated at a Macy Conference that the development of nurse-midwifery in the United States could not be conceived without the physician as the leader. He felt nurse-midwives were not equipped to define normality and this should be left up to the physician to decide. Patients should be able to be withdrawn from the case load without hard feelings by the nurse-midwife if the physician deems this necessary. The nurse-midwife should have the privilege of demanding consultation with a physician or returning an assignment if she decided this was necessary.[50]

Dr. Hellman stated he feared there was a real threat fragmentation of maternity care would result with the development of nurse-midwifery. He felt it was very possible for maternity care in the United States to be divided between obstetrician, nurse, and nurse-midwife each operating as a satellite in its own orbit, having little conversation or communication with each other and without responsibility for one another. A great tendency for individuals in health care is to stake out a claim which can only work to the detriment of patients and of the people involved. He does see areas in research where the nurse-midwife can make a significant contribution. But, the key in preventing serious fragmentation in maternity care is in communication at individual, hospital, and governmental levels. The nurse-midwife must present her own objectives but be willing to cooperate to achieve the common objective which Dr. Hellman states as "healthy mothers and healthy babies."[51]

---

[50]Hellman, The Training and Responsibilities of the Midwife, pp. 232-234.

[51]Ibid., pp. 235-236.

The patient is the individual directly affected by the skills and techniques of the nurse-midwife and whose opinion should be the most influential in determining the nurse-midwife's ultimate value. Immediate acceptance by the patients in one program studies seemed to stem from the warmth and the individuality in approach. At the time of writing of the article citing this study no patient had refused the services of a nurse-midwife although a choice was always offered.[52]

In a Boston city hospital the comments on nurse-midwifery care were:

> They were pleased to have been able to see their "special nurses" at each visit, because it gave them a reason for coming to clinic. All of the mothers felt that they would like this type of maternity care with the next pregnancy because, "It was good to know that there was someone who knew you, cared about you and could help you."[53]

Dr. Schuyler Kohl of Downstate Medical Center in Brooklyn stated the mothers frequently discussed personal matters including sexual problems much more freely with a midwife than a physician. He further commented their patients were extremely disappointed if they came back with their second pregnancy and were not assigned to a nurse-midwife.[54]

A study was done by Norma Swenson in 1968, on "The Role of the Nurse-Midwife on the Health Team as Viewed by the Family." She

---

[52]Lang, The Nursing Clinics of North America, p. 519.

[53]Josephine Sagebeer, "A Nurse-Midwife in a Boston City Hospital," Bulletin of the American College of Nurse-Midwifery, August, 1967, p. 103.

[54]_____, "Return of the Midwife," Newsweek, March 31, 1969, p. 107.

concluded that to the family the nurse-midwife was the single influence providing:

1. another level of professional competence and the increasing possibility that current inequities in maternity care will be removed

2. a synthesizing, coordinating, family point of view working to overcome the fragmenting discontinuity of present specialization

3. a screening agent to better insure appropriate care for both high risk and normal individuals and their families

4. a link between the hospital and the community (both potentially and actually)

5. an acknowledgment of social and psychological factors in both the management and outcome of maternity care

6. the encouragement of a sense of confidence in both mothers and fathers

7. and the addition of a prevention education component on the health team which should be the bulk of the work in a field so largely concerned with normal processes.[55]

In essence the midwife can be seen as the team member closest to the family and is in one of the best positions to develop new preventative programs.[56]

The government is an area that can assist the nurse-midwife in meeting her problems. The government must investigate the needs and provide the services to allow the practitioner to develop and improve her knowledge in nurse-midwifery by continued study, self-evaluation and consultation with other members of the profession.

---

[55]Norma Swenson, "The Role of the Nurse-Midwife on the Health Team as Viewed by the Family," Bulletin of the American College of Nurse-Midwifery, November 1968, p. 131.

[56]Ibid.

Government funds can provide the capital not supplied by anyone else.[57] Funds in the United States for the development of nurse-midwifery became available through the Children's Bureau stemming initially from the late President Kennedy's interest in the prevention of mental retardation.[58]

A professional organization is another important source of help for individuals in a new and emerging profession. This type of an organization assists the midwife in keeping up with the trends of her profession through refresher courses, liason with other professional organizations and governmental agencies.[59] Nurse-midwives have been excluded from the professional organizations of both nurses and physicians which speaks of the problem of communication. Mutual exclusion certainly will cut down the opportunity to attempt new solutions.[60] Nurse-midwives stated if they had been given membership to the medical organization as a splinter group the fact they wanted to maintain their identity with nursing on a specialist line would have ruled out this membership. Secondly, one of the policies of the American College of Nurse-Midwifery is nurse-midwives shall function only within the framework of existing health organizations meaning they are salaried personnel not setting up private domicilary practices.[61]

---

[57]Koinange, The Training and Responsibilities of the Nurse-Midwife, p. 249.

[58]Hellman, Ibid., p. 155.

[59]Koinange, Ibid., p. 252.

[60]Keane, The Midwife in the United States, p. 87.

[61]Ibid., p. 92.

However, Dr, Hellman stated he felt it might have been a forward looking development for the American College of Obstetrics and Gynecology to adopt nurse-midwifery as an integral part of maternity care, although he felt such an event was unlikely. He sees the American College of Nurse-Midwifery as a vigorous organization under excellent leadership. But, it represents fragmentation and as long as there is fragmentation the ultimate potential of maternity care will not be reached.[62]

In conclusion, Sir John Peel summed up the concept of nurse-midwifery as part of a team when he said:

> The all-purpose midwife is really as out-of-date as the all purpose doctor. This makes it all the more necessary for all personnel engaged in the care of patients to be very much more closely integrated if continuity of care is not to be utterly lost. As an integrated member of the team, she should get a much greater degree of satisfaction and a much closer liason with her professional colleagues. The woman would receive a much greater degree of continuity of care with her own family doctor and midwife in close liason. . .[63]

---

[62]Hellman, The Training and Responsibilities of the Nurse-Midwife, p. 236.

[63]John Peel, "The Future of the Maternity Services," Nursing Mirror, November 8, 1968, p. 30.

# PART II

# INTRODUCTION TO THE PROBLEM AND DESIGN OF STUDY

## INTRODUCTION TO THE PROBLEM AND DESIGN OF THE STUDY

The American Nurses' Association made the following statement on the profession of nurse-midwifery:

> Until fairly recently, utilization of nurse-midwives has been very limited, and many nurses prepared in nurse-midwifery did not utilize their skills. However, over the past few years, it has become increasingly clear that there is a great need to improve qu lity and extend quantity of maternity care in the country. Demonstration projects are being conducted in some parts of the country in which nurse-midwives are employed as members of the maternity care team and as a result of these demonstrations, the medical and public health professions are becoming more aware of the potential contribution of nurse-midwives in maternity care. . .[64]

The purpose of this research was to determine the extent to which the nurse-midwives' skills are being utilized in the health institutions of the midwest. The first hypothesis for this study was the nurse-midwife is not being utilized fully due to one or both of the following factors:

1) inability of the health institution to incorporate her skills into the framework of their organization

2) there is some form of resistance demonstrated by other professions or nonprofessionals which decreases her utilization

The second hypothesis is the personal qualifications required and the preparation in nurse-midwifery specifically does not vary greatly from one school to another in the United States so this is not a factor in their increased or decreased utilization.

---

[64] _____, "ANA Statement on Nurse-Midwifery," Bulletin of the American College of Nurse-Midwifery, February 1968, p. 26.

SURVEY OF LITERATURE

Published research in regard to the utilization of the nurse-midwives' skills in a health setting was not found. Thus, a discussion of new health disciplines experiencing some of the same problems and obstacles as nurse-midwifery will be undertaken.

A study done by Helen Ann Harrington and E. Charlotte Theis investigated the institutional factors preceived by baccalaureate graduates as influencing their performance as staff nurses. The presupposition of this study was hospitals overlook the potential contribution of baccalaureate degree nurses and thus fail to fully utilize the professional talent available. In this study three aspects of the five professional nursing functions were explored, these being:

1) the nurse's preceived ability to carry out the function

2) the institutional conditions and requirements that the nurse preceived as helping or hindering her in the performance of the function

3) any action the nurse might have taken to improve her ability to carry out the function.[65]

The study investigated "typical" and "ideal" hospital settings. One conclusion reached by both groups of nurses questioned was the attitude and expectations of those in authority were the single, most important influencing factor in determining how the individual staff nurse would utilize her skills. It was found in the "typical" hospitals these attitudes restricted the baccalaureate graduate from

---

[65]Helen Ann Harrington and E. Charlotte Theis, "Institutional Factors Perceived by Baccalaureate Graduates as Influencing their Performance as Staff Nurses," Nursing Research, May-June 1968, pp. 228-231.

fully utilizing professional skills primarily because the former did not appear to consider certain functions within the domain of the staff nurse or supervisor.[66]

Responses of nurses questioned in the "typical" hospital revealed they generally felt frequent assignment changes, the method of assignment, and the multitude of managerial and non-nursing tasks they were expected to perform fostered an action-oriented, work-centered climate. These same nurses also found informal group meetings, team conferences, written care plans, and meaningful reporting and charting were very helpful, however, they did not occur often enough and with any consistency. Inadequate communication with other professional workers also provided a stumbling block in designing nursing care plans.[67]

It became apparent that the inability of the baccalaureate degree nurse to perform professional nursing functions stems less from the nature and character of her preservice education than from conditions in the work environment that do not permit her to do so. Also, to what extent her concept of nursing is congruent with what she is expected to do on the job influences her utilization.[68]

Another area of health care is experiencing the advent of new professional people, this being dentistry. These new professional people are the dental hygienist and the New Zealand type dental nurse. There is a world wide shortage of fully trained dentists to meet the population explosion and increasing awareness of dental

---

[66] Ibid., p. 231. [67] Ibid., p. 233.

[68] Ibid., p. 234.

health in the developing countries. It is evident trained auxiliaries will play a more important role in the dental team.

The dental hygienist is educated for a period of less than one year to two years training in the United States. As found in the United States some schools require two years of college level study and then receive a degree after two years professional training. These individuals are legally recognized in the United States.

The New Zealand type dental nurse has become more widely utilized since 1960. The length of training varies from forty months to three years. Her duties include:

1) exam

2) prophylaxis including scaling, and removing stains

3) filling deciduous and permanent teeth under local anesthesia

4) radiographic exam of the teeth and supporting structures.[69]

The New Zealand type nurse has received increasing acceptance as a result of the acute shortage of dentists. Also attitude changes have been seen by the new types of legislation in these countries to provide for this individual's service.

It has become the general concensus of those involved with the utilization of these new team members that there should be a general agreement on the range of duties, degree of responsibility, and length and content of training course for the different types of auxiliary worker. These standards must be established and set by the dental profession.[70]

---

[69] G. H. Leatherman, "Survey of Auxiliary Dental Personnel," International Dentistry Journal, March, 1969, pp. 50-53.

[70] Ibid., pp. 52-54.

It appears the most effective solution to the lack of qualified dentists is to utilize maximally the knowledge and training of dentists and for them to delegate to specially trained auxiliaries those areas of treatment which can be safely assumed by others with an adequate level of training. The dentist should be educated to understand and accept the role of auxiliary personnel performing the more routine aspects of conservative dentistry.[71] With the efficient use of auxiliary help the dentist can increase his volume and variety of patients while at the same time reduce the physical stress to which he is subjected.[72]

An interesting address was made by Dr. Richard I. Evans, professor of psychology at the University of Houston for the American Society of Medical Technologists convention. His topic was the "Identity Crisis for an Emerging Profession". Dr. Evans states new innovations affecting the medical profession infringe on the profession's members self-identity and also how he is viewed by society. He sees himself doing things the traditional way and so does society, thus he resists change. As a result, an emerging profession must decide if it wants to play the role of child to overpowering Father Figure, or in relationship to the physician which implies some form of equality, a profession to profession relationship. The role of the new profession must not become fixated at a level of dependency forever.

---

[71] Ibid., p. 54.

[72] G. Th. E. R. Arnold, "The Dental Assistant, the Clinical Chairside Assistant and the Dental Hygienist as Members of the Dental Team in General Practice," International Dentistry Journal, March 1969, p. 19.

[73] Richard R. Evans, "Identity Crisis for an Emerging Profession," American Journal of Medical Technology, September 1968, p. 492.

With the growth and development in the medicine related areas such as biochemistry and the entire instrumentation field a point has been reached that it is obvious there is no super breed of professionals who can carry the ball completely. There must be in other groups enough autonomy, self-sufficiency and security to share the responsibility to the public. Quality comes from the group involved and not the group over it.

The problem of recruitment into a new profession is greatly influenced by how the group is perceived by the outside, says Dr. Evans. Resistance to the profession can be divided into two areas, these being:

1) "reality-bound" which are rational areas of resistance
2) emotional and irrational resistance which cannot be pinpointed as realistic blocks to the profession.

Inside the organization the members can represent areas of resistance. There are those individuals that are considered "localities" who are dedicated to the local situation and resist change. Then one finds those receptive to change who remove themselves from the narrow confines of the institution and attempt to see broader horizons for their group. These being the "cosmopolites." The last group is simply termed indifferent. This group is not committed for or against change. These people are often the ones who can be influenced most drastically once the action begins.[74]

The third influential area of resistance is in the general public and the almost mystical respect with the title of doctor.

---

[74] Ibid., pp. 493-496.

This public resistance reflects itself also politically in state legislatures and Congress. But, what must be kept in mind is the public's attitudes can be changed quickly and today there seems to be the greatest receptivity ever experienced in the history of medicine on the idea of greater professional identity.

In conclusion, Dr. Evans stated the profession's self-image could be a powerful contribution to the medical health of society and the profession itself. As the profession develops standards of ethics, quality of service, and becomes functional at a higher and higher level, autonomous professional services will improve. There will result a greater infusion of health services, and medicine will have more freedom for other persuits. In the long run the public will experience a tremendous gain.[75]

DISCUSSION OF RESEARCH QUESTIONNAIRE

The subjects for this study included sixty-eight nurse-midwives from the midwest who are members of the American College of Nurse-Midwifery. Mississippi was included in the study as the questionnaires were forwarded to individuals in Mississippi who had recently moved from a midwestern state. In formulating the questions reference was made to the article by Marion Strachan, "Functions, Standards, and Qualifications of Nurse-Midwives in a Hospital Obstetric Service," in the Bulletin of the American College of Nurse-Midwifery, September 1960. The instrument used for collecting data was in the form of a questionnaire which generally required a checked response and two questions designed for an open response.

---

[75] Ibid., pp. 497-501.

A division was made as to specific functions performed by the nurse-midwife and those who performed them were classified as clinician, teacher or supervisor, and administrator. Thus, it was feasible for a nurse-midwife in viewing her functions to be considered as a clinician and a supervisor, or some other combination would be possible. These individuals were tallied for each of the sections. The questions under number three were so stated to assist me in determining the nurse-midwife's classification if she was unable to respond to any of the questions that followed.

In catergorizing the nurse-midwife as to how she was classified in relation to her profession the terms direct, related, or non-related were used as defined by the American College of Nurse-Midwifery. If the nurse-midwife performed the skills of a clinician plus other skills she was considered in direct nurse-midwifery by definition. If the individual performed the skills of a supervisor or administrator but not clinician she was considered in a midwifery related service by definition. This questionnaire was designed to obtain information from the nurse-midwife working in a hospital setting or clinic and did not cover the aspects of a maternal-child coordinator or a domicilary nurse-midwife. A sample questionnaire and the statistical analysis of the research follows.

## STATISTICAL ANALYSIS

Sixty-eight questionnaires were sent out to nurse-midwives in the midwest and a return of forty-seven questionnaires or 69.1 percent was received from the total.

Dear Nurse-Midwife:

I am a senior nursing major at Illinois Wesleyan University and am doing a project to receive departmental honor. I am studying the utilization of the nurse-midwife's skills in the midwest and this is the reason I am asking for your assistance. From the information I receive I hope to be able to draw some conclusions as to the extent of the nurse-midwife's contribution to the improvement of maternal and child care. Thus, your completion of this questionnaire will determine the success of my endeavors. Please return by December 8, 1969. Thank you for your cooperation.

Sincerely,

Gwen Ohlendorf

DEFINITION OF TERMS:

The following terms were defined by the American College of Nurse-Midwifery.

Direct Midwifery Service-- "is the functioning of the nurse-midwife in the actual practice of midwifery." (includes nurse-midwife education)

Midwifery Related Service-- "is that field of practice in which the nurse-midwife functions in areas of maternal and child health such as: Obstetrics, Pediatrics, Maternal and Child Health, Parent Classes, Maternal and Infant Care ("500") Projects and, in activities with a high component of services for mothers, parents, infants and children, as an administrator, consultant, supervisor, public health nurse, instructor, staff nurse, etc."

Non-related Service-- "is that in which the nurse-midwife functions in areas of practice not related to midwifery or maternal and child health, but including nursing."

---

State of residence: _____

Age: 20-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 61 and over (circle)

1. Do you possess:

_____ A. a certificate in nurse-midwifery
_____ B. a B. S. with certificate in nurse-midwifery
_____ C. a M. A. with certificate in nurse-midwifery
_____ D. a PhD. with certificate in nurse-midwifery

2. At the present time, are you employed? _____yes _____no

3. A. Where are you employed? _____

B. What position do you hold? _____

4. If you are considered a clinician in nurse-midwifery are you able to perform the following functions?

In COLUMN I check if you were PREPARED TO perform the skill.
In COLUMN II check YES or NO if you presently UTILIZE this skill.

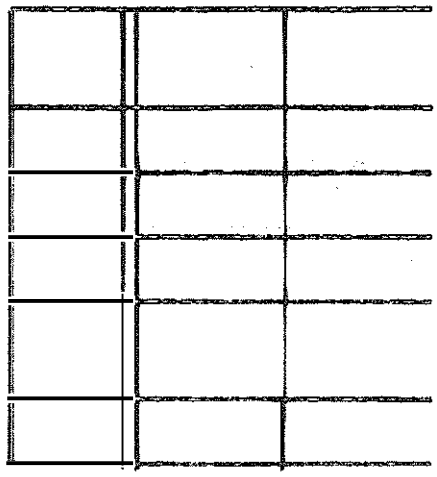
| | I | II | |
|---|---|---|---|
| | Prepared | Utilize yes | Utilize no |
| A. take medical histories | | | |
| B. examine patients, including weight, B/P, breast, abdomen, pelvis and pelvic organs | | | |
| C. evaluate obstetrical status with the doctor and patient | | | |
| D. plan and provide health supervision and education | | | |
| E. provide instruction in psychoprophylaxis and preparation for lactation | | | |
| F. perform necessary emergency lab procedures | | | |
| G. manage labor and delivery | | | |
| a) inhalation (nitrous oxide and $O_2$ or Trilene) | | | |
| b) pudendal block | | | |
| c) I. V. anesthesia | | | |
| d) episiotomy and repair | | | |
| e) manual removal of placenta | | | |
| f) breech or twin delivery | | | |
| g) surgical induction | | | |
| H. provide immediate newborn care | | | |
| I. make periodic visits to mother and babies and evaluate condition | | | |
| J. function as a family planning instructor | | | |
| K. assist in research programs of maternity care | | | |

5. If you are employed as a teacher or supervisor in nurse-midwifery or maternal-child nursing, check the functions you perform.

| | |
|---|---|
| A. provide instruction and learning experiences for students | |
| B. initiate and participate in the studies for the improvement of educational programs and patient care programs | |
| C. participate in the formulation and maintanence of comprehensive, accurate, and up-to-date record systems | |


D. guide, supervise and teach basic students in learning the principals of maternity care

10. If you are employed as an administrator, check the functions you perform.



A. develop a program structure, philosophy, and objectives and help to create good working relations with other personnel
B. analyze and evaluate the needs of the obstetric program
C. provide for personnel to meet the needs of the obstetric service
D. set standards for nurse-midwife education and patient care
E. assist in the improvement of communication and interpretation with patients and personnel
F. participate in related community activities

11. Do you believe you are being utilized in your place of employment to the best of your ability as a certified nurse-midwife? _____yes _____no

12. If no, please list how your services could be put to better use.

13. If you experience any resistance in your place of employment, does this chiefly originate from the:

_____A. hospital administration
_____B. medical profession
_____C. nursing profession
_____D. non-professional personnel (specify) _____
_____E. patients and their families
_____F. other (specify) _____

14. If so, what seems to be the basic cause of this resistance?

Thirteen states were represented in the total return. Table 1 shows Illinois had the largest return with 21.3 percent of the total, followed by Ohio with 19.1 percent of the total and Kentucky with 14.9 percent of the total.

TABLE 1

RETURN BY STATES

| State | Return |
|---|---|
| Illinois | 21.3 |
| Indiana | 4.3 |
| Iowa | 4.3 |
| Kentucky | 14.9 |
| Michigan | 8.5 |
| Minnesota | 6.3 |
| Mississippi | 4.3 |
| Missouri | 2.1 |
| Nebraska | 2.1 |
| Ohio | 19.1 |
| Pennsylvania | 2.1 |
| Tennessee | 4.3 |
| Wisconsin | 6.3 |

Table 2 illustrates the range of age of the respondents with the span forty-six to fifty having 25.5 percent of the total being the largest percentage, and the age group twenty to twenty-five having 2.1 percent of the total demonstrating the smallest percentage of nurse-midwives. Information was withheld by 6.3 percent of the respondents on this question.

TABLE 2

RANGE OF AGE

| Age | Return |
|---|---|
| 20-25 | 2.1 |
| 26-30 | 8.5 |
| 31-35 | 12.8 |
| 36-40 | 12.8 |
| 41-45 | 10.6 |
| 46-50 | 25.5 |
| 51-55 | 6.3 |
| 56-60 | 10.6 |
| 61 & over | 4.3 |
| Withheld | 6.3 |

A certificate of nurse-midwifery was possessed by 27.7 percent of the total number of respondents. A bachelor of science degree was held by 29.8 percent, master of science by 17.0 percent and a doctorate by 2.1 percent of the total. This information was withheld by 4.3 percent of the total number of respondents. Of the nurse-midwives who considered themselves unemployed, one was working on her bachelor of science degree, one on her master of science degree and another was a full-time doctoral candidate.

The percentage of those employed full time was 85.1 percent. One respondent worked part-time and 12.8 percent of the total were unemployed at the time they received this questionnaire.

Of those employed, sixteen respondents or thirty-four percent, were working in direct nurse-midwifery which was defined as functioning in the actual practice of nurse-midwifery or nurse-midwifery education.

Those working in related nurse-midwifery numbered twenty-one respondents or 44.7 percent of the total, this being defined as functioning in areas of maternal child health or in activities with a high component of services for mothers, parents, infants and children as an administrator, consultant, public health nurse, or staff nurse. There were four respondents or 8.5 percent of the total that were practicing in a non-related service which included areas not related to midwifery or maternal child health, but included nursing. The last percentage of respondents were unemployed and made up 12.8 percent of the total population studied.

The question related to the place of employment and the position held was asked to obtain information that would be of assistance in determining the classification of the nurse-midwife as either direct, related or nonrelated. Also this question gave an indication of the type and variety of places of employment a nurse-midwife in the above classification functioned, but was not deemed pertinent to be included in the statistical analysis.

Question four dealt with the skills of the nurse-midwife who was classified as a clinician. A total of fifteen nurse-midwives were found to be working in this area. Table 3 on the skills of the nurse-midwife clinician illustrates the degree of preparedness and the utilization or lack of utilization of the specific functions by the nurse-midwife. Part C of question four, the evaluation of the obstetrical status with the doctor and patient showed 93.3 percent of the toal were prepared for this function, 6.7 percent withheld information of preparedness. Utilization of this skill totalled

TABLE 3

THE NURSE-MIDWIFE CLINICIAN

| | Skills | Prepared | Withheld | Yes | No | Withheld |
|---|---|---|---|---|---|---|
| A. | take medical histories | 93.3 | 6.7 | 80.0 | 20.0 | 0 |
| B. | examine patients, including weight, B/P, breast abdomen, pelvis and pelvic organs | 93.3 | 6.7 | 86.7 | 13.3 | 0 |
| C. | evaluate obstetrical status with the doctor and patient | 93.3 | 6.7 | 93.3 | 6.7 | 0 |
| D. | plan and provide health supervision and education | 93.3 | 6.7 | 80.0 | 20.0 | 0 |
| E. | provide instruction in psychoprophylaxis and preparation for lactation | 93.3 | 6.7 | 80.0 | 13.3 | 6.7 |
| F. | perform necessary emergency lab procedures | 86.7 | 13.3 | 66.7 | 26.7 | 6.6 |
| G. | manage labor and delivery | 46.7 | 53.3 | 40.0 | 6.7 | 53.3 |
| | a) inhalation (nitrous oxide and $O_2$ or Trilene) | 66.7 | 33.3 | 73.3 | 26.7 | 0 |
| | b) pudendal block | 66.7 | 33.3 | 33.3 | 46.7 | 20.0 |
| | c) I.V. anesthesia | 40.0 | 60.0 | 26.7 | 46.7 | 26.6 |
| | d) episiotomy and repair | 80.0 | 20.0 | 53.3 | 33.3 | 13.4 |
| | e) manual removal of placenta | 53.3 | 46.7 | 26.7 | 46.7 | 26.6 |
| | f) breech or twin delivery | 80.0 | 20.0 | 53.3 | 46.7 | 0 |
| | g) surgical induction | 53.3 | 46.7 | 20.0 | 53.3 | 26.7 |
| H. | provide immediate newborn care | 93.3 | 6.7 | 86.7 | 13.3 | 0 |
| I. | make periodic visits to mother and babies and evaluate condition | 93.3 | 6.7 | 66.7 | 33.3 | 0 |
| J. | function as a family planning instructor | 80.0 | 20.0 | 73.3 | 20.0 | 6.7 |
| K. | assist in research programs of maternity care | 53.3 | 46.7 | 40.0 | 33.3 | 26.7 |

TABLE 4

THE NURSE-MIDWIFE AS TEACHER OR SUPERVISOR

| | Functions | Prepared | Withheld | Yes | No | Withheld |
|---|---|---|---|---|---|---|
| A. | provide instruction and learning experiences for students | 76.5 | 23.5 | 94.1 | 5.9 | 0 |
| B. | initiate and participate in the studies for the improvement of educational programs and patient care programs | 58.8 | 41.2 | 70.6 | 11.8 | 17.6 |
| C. | participate in the formulation and maintenance of comprehensive, accurate, and up-to-date record systems | 52.9 | 47.1 | 64.7 | 17.6 | 17.7 |
| D. | guide, supervise and teach basic students in learning the principals of maternity care | 70.6 | 29.4 | 88.2 | 5.9 | 5.9 |

TABLE 5

THE NURSE-MIDWIFE AS ADMINISTRATOR

| | Functions | Prepared | Withheld | Yes | No | Withheld |
|---|---|---|---|---|---|---|
| A. | develop a program structure, philosophy, and objectives and help to create good working relations with other personnel | 50.0 | 50.0 | 90.0 | 0 | 10.0 |
| B. | analyze and evaluate the needs of the obstetric program | 50.0 | 50.0 | 80.0 | 10.0 | 10.0 |
| C. | provide for personnel to meet the needs of the obstetric service | 50.0 | 50.0 | 70.0 | 20.0 | 10.0 |
| D. | set standards for nurse-midwife education and patient care | 40.0 | 60.0 | 30.0 | 40.0 | 30.0 |
| E. | assist in the improvement of communication and interpretation with patients and personnel | 60.0 | 40.0 | 10.0 | 0 | 90.0 |
| F. | participate in related community activities | 60.0 | 40.0 | 80.0 | 10.0 | 10.0 |

93.3 percent of the respondents with non-utilization demonstrated by 6.7 percent of the total. Part B and H of question four, the examination of the patient including weight, blood pressure, breast, abdomen, pelvis and pelvic organs and providing immediate newborn care respectively, received a response of preparedness of 93.3 percent with 6.7 percent withholding information. Utilization of these skills were performed by 86.7 percent of the total while 13.3 percent did not utilize the skills. Surgical induction, part G section g. of question four was the skill least utilized as 53.3 percent stated they were prepared and 53.3 percent of the total stated they did not utilize the skill.

Question five was answered by seventeen nurse-midwives. Part A of question five, providing of learning experiences, received 76.5 percent of the total in regard to preparation with 23.5 withholding this information. Ninety-four percent stated they utilized this skill and 5.9 percent did not utilize it. This question received the highest response in regard to utilization. Table 4 on the skills of the nurse-midwife as a teacher or supervisor will illustrate the responses to the other questions in that section.

Question six dealt with the nurse-midwife who functions as an administrator. The results from ten respondents showed that out of fifty percent who answered they were prepared to develop a program structure, philosophy and objectives and help to create good working relations with other personnel, ninety percent stated they utilized this skill and ten percent withheld the information.

In response to the question of assisting in the improvement of communications and interpretation with patients and personnel, sixty

percent stated they were prepared but ten percent stated they utilized the skill and ninety percent withheld the information. Table 5 on the skills of the nurse-midwife as administrator contains the information pertaining to the rest of the questions.

Thirty-four percent of the total number of respondents believed they were being utilized fully and 44.7 percent felt they were not being fully utilized while 21.3 percent withheld this information.

The following is a summary of the responses to question twelve on how the nurse-midwives thought they could be better utilized.

1. Perform deliveries in emergency situations
2. Be wholeheartedly endorsed by the obstetricians as a nurse-midwife and be able to perform the acquired skills (two respondents)
3. Perform routine deliveries and give hospital care (three respondents)
4. Assist in the prevention of handicapping conditions in children
5. Teach sex hygiene and education for retarded children and their families
6. Participate in the maternal and child health courses in the school of nursing and public health
7. Participate in expectant parent classes
8. Assist in prenatal clinics
9. Assist with family planning classes
10. Become part of nursing service planning and in-service education for the unit
11. Work with community groups for better continuity of care
12. Act as a resource person in antipartal, delivery and post-partal areas

13. Be able to function as a nurse-midwife in present place of employment (two respondents)

Two of the nurse-midwives stated they were not being utilized due to the fact they had too many other duties that kept them away from nursing or nurse-midwifery and suggested a clerk be hired to relieve them of this paperwork. Also some of the hospitals teach medical students, interns, and residents and therefore these people compete for the patients. Finally, the reason for lack of full utilization was their places of employment did not accommodate the skills of a nurse-midwife.

In response to areas of resistance nurses were 12.8 percent of the total from twenty-four responses. The same individual may have marked more than one area, but each entry was counted as a response. Doctors resulted in 21.3 percent of the total with nurse's aides as 2.1 percent and state laws as 12.8 percent of the total. No resistance by hospital administration or patients and their families was experienced by those who answered this question.

The following list is a summary of the responses to question fourteen on the causes of resistance experienced by nurse-midwives.

MEDICAL PROFESSION:

1. Nurse-midwives pose a threat to a physician's obstetric practice
2. Physicians are influenced by the rules of an obsolete County Board of Health. As a result principles and practice of family-centeredness are difficult to implement
3. The physicians have not had the opportunity to work with nurse-midwives and thus they feel they are only able to function as nurses
4. The resident staff is concerned about liability and the role of the nurse-midwife in a university hospital

5. The physicians are unfamiliar with the nurse-midwife's knowledge and skills and as a result are afraid of her. (four respondents)

NURSES:

1. Public health nurses have resented the nurse-midwives as they feel if monies allotted for special projects would have been given to the health department the job could have been done as effectively

2. Shortage of nurses and resistance to change are factors

3. Nurses, in general, have some "fear" of the nurse-midwive's experience and training in regard to salary and position level

4. Nurses view change with hostility and excuses

5. Ignorance of the nature of nurse-midwifery practice which is evidenced by those who have a negative attitude are ignorant of what a nurse-midwife really is.

STATE LAWS:

1. Michigan does not recognize nurse-midwives

2. Ohio medical board has not yet written an exam so the nurse-midwife can be licensed. One is being prepared for December or January 1970 (three respondents)

3. The state of Minnesota does not recognize the nurse-midwife

4. The state of Tennessee does not presently have any laws, rules, or regulations governing the practice of nurse-midwifery

5. Nurse-midwifery is illegal in Illinois according to the Medical Practice Act

6. Nurse-midwives are not licensed to practice in Indiana.

In conclusion, one respondent highlighted the major area of resistance she received by doctors, nurses and auxiliary personnel in the following statements:

1) Apparent lack of motivation for internal improvement and complacency with status quo

2) Fear of change and its effect on traditional attitudes and ways of doing things

3) Professional jealousy

4) Failure to consider the patient as the center focus of service

5) Reluctance to listen to or allow the consumer to have a voice or choice in the services offered and/or needed

6) In-breeding in terms of personnel concerned with services and overconcern with the economic (monetary) aspects of service and operations

7) Insulation in relation to services rendered by particular groups with a lack of communication between groups in the community concerned with health in the maternal-child aspect

8) Deeply engrained hierarchy in the delivery of medical care.

## DISCUSSION OF IMPLICATIONS

In returning to the first hypothesis nurse-midwives are not being fully utilized as evidenced by the yes and no response to question eleven where 44.7 percent stated they were not being fully utilized although the percentage was smaller than at first anticipated as there was only 10.7 percentage points from those who felt they were being utilized. Evidence of the health institutions inability to utilize the skills of the nurse-midwife was brought forth in the open response question on areas nurse-midwives felt further utilization could be facilitated. These responses ranged from allowing the individuals to perform the clinical skills of the nurse-midwife such as management of labor and delivery to the skills of assessment, teaching, community work, and planning projects related to maternal and child nursing. These last areas do not require special legislation or policy change, but simply a realization of the potential benefit of the nurse-midwive's advanced knowledge and training in areas of maternal and child health.

The areas of resistance were evidenced in questions thirteen and fourteen with physician resistance heading the list. Most of the resistance seemed to result from a lack of knowledge of the individual's abilities and special skills. On the other hand the resistance from the various states was not anticipated and this, of course, denotes a legislative obstacle that needs to be handled.

The second hypothesis stated there was little difference in the general preparation of the nurse-midwife in the various schools, so this would not be a factor in their skills not being utilized. The responses to question four seemed to varify this hypothesis with possibly the exception of intravenous anesthesia in which only six of the fifteen respondents stated they were prepared to perform this skill. The rest of the skills were generally a part of the nurse-midwife's preparation. From this information it was concluded education did not influence utilization or lack of utilization.

Consistent responses to all questions in the areas of the skills of the clinician, teacher, supervisor and administrator were not obtained. Several respondents neglected to check if they had been prepared in the areas to which they responded. This may have been the result of the absence of a column asking if they were not prepared in that particular area. As a result, there was no accurate way to determine if the information withheld was the result of unpreparedness in a certain area, a deliberate attempt to withhold this information, or the question was not applicable to their position. Another area of confusion on this same topic could have come from the fact the term "prepare" was not defined as meaning formal rather than functional education. It was also felt that section G of question four

was inadvertently neglected by many respondents as it appeared to be regarded as a general heading and not a specific question. This was concluded because those same people who did not state they utilized the skills of managing labor and delivery went on to utilize the skills directly under that question which could not be performed without the ability to manage labor and delivery. Finally, the people working in the area of public health were unable to respond to many of the questions as it was basically oriented to hospital workers and an accurate inventory of people in the public health services' skills was not taken. These factors may or may not have had bearing on the results and the conclusions drawn, but needed to be presented as influencing factors.

The analysis of this questionnaire brings to light other areas that could be investigated. It was demonstrated most nurse-midwives function in the area of related nurse-midwifery where the clinical skills are not as fully utilized as the skills of assessment, observation, teaching, counseling and research, all of which are nursing skills but have been intensified by the special education these nurse-midwives have received. Several respondents were already working as public health consultants or instructors in maternal and child health. These above skills were emphasized by the nurse-midwives in the question asking how they could be better utilized and are apparently areas nurse-midwives believe they can be of value. In these areas they are not taking on the physician's duties of managing the technical skills of pregnancy, but are utilizing their mental abilities to promote the nursing care of pregnant families. A study investigating this individual's role, her abilities and

limitations, and actual utilization would prove interesting as this appears to be the area the nurse-midwife is beginning to find herself being placed and where she could attain a high degree of autonomy.

Another area for study would be the investigation of the progress the state legislatures have made in legalizing and licensing the nurse-midwife. This area presented itself as a formidable point of resistance as stated by the respondents to this questionnaire. This is an area the American College of Nurse-Midwives could be of assistance in promoting licensure and through this make a definite statement as to the nurse-midwives qualifications and skills.

Finally, the average age of the nurse-midwife was shown to be above thirty, the greatest percentage between forty-six and fifty. This seems to indicate nurse-midwifery is either not attractive to the younger nurse or the popularity of nurse-midwifery is fading and new nurses are not being interested by this field. A study of the validity of this hypothesis and the reasons for it and methods being undertaken to correct this situation would be interesting.

## SUMMARY

The problem presented was to what extent is the nurse-midwife's skills being utilized in the midwest. The procedure followed was to survey by questionnaire sixty-eight nurse-midwives in the above mentioned area. The major findings were: 1) nurse-midwives in the midwest are not being fully utilized, 2) nurse-midwives are not being utilized fully because their places of employment do not monopolize on their abilities and skills, 3) nurse-midwives receive resistance

from doctors, nurses, nonprofessionals and state laws or the lack of laws legalizing this profession, 4) educational backgrounds did not seem to be a factor in the utilization or lack of utilization of the nurse-midwife.

Conclusions reached were the nurse-midwife's greatest use seems to run in the line of related nurse-midwifery where she does not borrow skills from the doctor, but rather enlarges and intensifies skills of the nurse to bring about a unique service aimed at the pregnant family. In her skills as a nurse-midwife clinician she can provide a valuable service to reducing the obstetric load of obstetricians, but her special abilities as a highly skilled nurse must not be overlooked and given a second seat to that of a physician's assistant. Her role may be in a period of transition and it is necessary for the nurse-midwife to make a definite statement of her qualifications, objectives, roles, skills, and limitations before she will be able to find the area in which she can provide her greatest service.

## CONCLUSION

From a rather lowly responsibility this midwife has emerged as a key member of the obstetrical team in which each individual contributes his special talents to produce a formidable complex.[76]

---

[76]S. E. G. Roch, "Divided We Fall," Midwive's Chronicle and Nursing Notes, July, 1968, p. 243.

The nurse-midwife has a tremendous potential and it would seem much more logical and medically sould to redirect her focus of care into the realm of normal obstetrics predominantly within the middle class structure rather then continuing to nuture the "status quo" position with unquestioned obedience.[77]

As is set forward in the American Nurses' Association statement on nurse-midwifery:

> Consideration should be given to the possibility of interpreting the practice of nurse-midwifery, under medical supervision, as being an appropriate delegation of responsibility by the physician to qualified nurse-midwives. We have found many precedents where the medical profession has found it acceptable to prescribe and delegate to others functions of increasing responsibility involving a substantial degree of judgment and skill that were heretofore termed "medical practice."[78]

There is always a continuing need for the nurse who understands the physical and emotional requirements of pregnant women and their families and is educated and equipped temperamentally to satisfy them. As Dr. Louis M. Hellman summarizes:

> Nurse-midwifery gives the nurse interested in maternity care a work area in which she can find deep personal satisfaction and a sense of professional achievement.[79]

If nurse-midwifery can continue to provide this type of reward it will enjoy a long and prosperous existence.

---

[77] Joan Von Ruden, "A Challenge for the Future," Bulletin of the American College of Nurse-Midwifery, February, 1968, p. 7.

[78] _____, "ANA Statement on Nurse-Midwifery," p. 27.

[79] _____, "Nurse-Midwifery a New Career for Nurses," New York Maternity Center Association, p. 4.

# BIBLIOGRAPHY


Arnold, G. Th. E. R. "The Dental Assistant, the Clinical Chairside Assistant and the Dental Hygienist as Members of the Dental Team in General Practice." International Dentistry Journal, 19:12-23, March 1969.

Butler, Neville R., Hellman, Louis M., Koinange, M. W., Satterthwaite, Adaline P. The Training and Responsibilities of the Midwife. New York: Josiah Macy Jr. Foundation, 1967.

Corbin, Hazel. "Historical Development of Nurse-Midwifery and Present Trends." Bulletin of the American College of Nurse-Midwifery, 4:14*, March, 1959.

Davis, Dorothy Craine and Middleton, Lamar. "Rebirth of the Midwife." Today's Health, February 1968, p. 28.

Evans, Richard R. "Identity Crisis for an Emerging Profession." American Journal of Medical Technology, 34:489-501, September, 1968.

Harris, David. "The Development of Nurse-Midwifery in New York City." Bulletin of American College of Nurse-Midwifery, February, 1969, p. 11. quoting Sister M. Theophane Shoemaker. History of Nurse-Midwifery in the United States. Washington D. C.: Catholic University Press, 1947.

Harrington, Helen Ann and Theis, Charlotte E. "Institutional Factors Perceived by Baccalaureate Graduates as Influencing their Performance as Staff Nurses." Nursing Research, 17:228-231, May-June, 1968.

Hellman, Louis M. "Nurse-Midwifery in the United States." Journal of Obstetrics and Gynecology, 30:883-8, December, 1967.

Keane, Vera. "The Nurse-Midwife: Clinical Nursing Specialist." Bulletin of the American College of Nurse-Midwifery, 12:71-4, August, 1967.

Keane, Vera. "The Role of the Nurse-Midwife in the United States Today." The Midwife in the United States, New York: Josiah Macy Jr. Foundation, 1968.

Keane, Vera. "Where Are We Going?" Bulletin of the American College of Nurse-Midwifery, 10:1*, Spring, 1965.

Lang, Dorothea M. "Providing Care Through A Nurse-Midwifery Service Program." The Nursing Clinics of North America, Philadelphia: W. B. Saunders Company, September, 1969.

Leatherman, G. H. "Survey of Auxiliary Dental Personnel." International Dentistry Journal, 19:49-54, March, 1969.

McCarthy, Mary A. "Infant, Fetal and Maternal Mortality." in U.S. 1963 Vital and Health Statistics System Series 20, U.S. Department of Health, Education, and Welfare Public Health Service, September, 1966.

Peel, John. "The Future of the Maternity Services." Nursing Mirror, 127:27-30, November, 1968.

Petty, May. "Maternity Nursing Concepts Reported by Nurse-Midwives," Bulletin of the American College of Nurse-Midwifery, 12:83-90, August, 1967.

Roch, S. E. G. "Divided We Fall," Midwive's Chronicle and Nursing Notes, 81:242-3, July, 1968.

Runnerstrom, Lillian. "Nurse-Midwifery at the Crossroads." Bulletin of the American College of Nurse-Midwifery, 12:119-22, November, 1967.

Sagebeer, Josephine. "A Nurse-Midwife in A Boston City Hospital." Bulletin of the American College of Nurse-Midwifery, 12:99-105, August, 1967.

Stallworthy, John. "Changes in Midwifery--Progress or Regression." Nursing Mirror, February 7, 1969, pp. 34-35.

Strachan, Marion. "Statements of Functions, Standards and Qualifications for the Practice of Nurse-Midwifery." Bulletin of the American College of Nurse-Midwifery, 11:55-68, July, 1966.

Swenson, Norma. "The Role of the Nurse-Midwife on the Health Team as Viewed by the Family." Bulletin of the American College of Nurse-Midwifery, 13:125-33, November, 1968.

U.S. Department of Health, Education, and Welfare. Report of five conferences held during 1967. Optimal Health Care of Mothers and Children: a national priority. National Institutes of Health Publication, 1967.

Von Ruden, Joan. "A Challenge for the Future." Bulletin of the American College of Nurse-Midwifery, 13:6-8, February, 1968.

Wilbur, Dwight L., Dennis, James L., Greene, John W., et. al., "The Nation's Health Manpower." in Papers from the First National Congress on Socio-economics of Health Care, Chicago, Illinois, January 22-23, 1967, Chicago, Illinois: Council on Medical Service and the Division of Socio-economic Activities of the American Medical Association, 1967.

_____. "ANA Statement on Nurse-Midwifery." Bulletin of the American College of Nurse-Midwifery, 13:26-27, Februar , 1968.

_____. "Nurse-Midwifer a New Career for Nurses." New York Maternity Center Association, p. 4.

## SELECTED BIBLIOGRAPHY

Beazley, J. M. "Labor Pain--How Much Are Midwives to Blame." Nursing Mirror, 127:19-21, November, 1968.

Berman, David S. "Utilization of the Dental Auxiliary--School Dental Nurse." International Dentistry Journal, 19:24-40, March, 1969.

Borsellega, J. "The Role of a Midwife in a Voluntary Hospital." Bulletin of the American College of Nurse-Midwifery, 12:131-4, November, 1967.

Faison, Jere B. "The Obstetrician and the Nurse-Midwife." Bulletin of the American College of Nurse-Midwifery, 4:89, March, 1959.

Jackson, N. and Vernon, M. "Modern Midwifery--Two Viewpoints." Nursing Mirror, 128:42, January, 1969.

Malkin, H. "Wider Horizons in Midwifery." Nursing Mirror, 26:32-3, May, 1968.

Perkes, R. "The Midwife--For Whom the Bell Tolls." Nursing Mirror, 128:14-7, January, 1969.

Stephen, E. "The Noble Art of Midwifery." Nursing Times, October, 1966, pp. 1350-2.

Sundberg, A. "Nurse-Midwife in a Urban Health Department." Bulletin of the American College of Nurse-Midwifery, 11:92-102, February, 1968.

_____, "More Flexible Use of Midwives." Nursing Mirror, February 16, 1968, pp. 10-11.

# SOURCES CONSULTED


1. Downstate Medical Center
   450 Clarkson Avenue
   Brooklyn, New York

2. The Royal College of Midwives
   15 Mansfield Street
   London, England

3. Dorothea M. Lang, Director
   Nurse-Midwifery Service Program
   Maternal and Infant Care Projects
   40 Worth Street, Room 814
   New York, New York

4. University of Utah
   Salt Lake City, Utah

5. American College of Nurse-Midwives
   50 East 92nd Street
   New York, New York

6. Frontier Nursing Service
   Wendover
   Leslie County, Kentucky

7. The John Hopkins University
   School of Hygiene and Public Health
   Department of Population and Family Health
   615 North Wolfe Street
   Baltimore, Maryland

8. Catholic Maternity Institute
   417 East Palace Avenue
   Santa Fe, New Mexico

9. Columbia University
   622 West 168th Street
   New York, New York

10. Graduate School of Nursing
    New York Medical College
    5th Avenue at 105th Street
    New York, New York

11. The Catholic University of America
    Washington D.C.

12. Yale University School of Nursing
    310 Cedar Street
    New Haven, Connecticut

13. School of Nurse-Midwifery
Department of Obstetrics and Gynecology
University District Hospital
Caparra Heights, Puerto Rico

14. Central Midwives Board
39 Harrington Gardens
South Kensington
London