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RESEARCH

Tensions and Teamwork in Nursing and Midwifery Relationships

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ABSTRACT

Objective: To explore the practice of midwifery within a busy urban tertiary hospital birth setting and to present findings on the relationships between nurses and midwives in providing maternity care.

Design/Method: A focused ethnography on midwifery practice conducted over 2 years (2004-2006) in a teaching hospital serving a primarily Medicaid-eligible population in Northern California. Data were collected through participant observations and in-depth interviews with midwives ($N = 11$) and nurses ($N = 14$). Practices and relationships among the midwives and nurses were examined in an ethnographic framework through thematic analysis.

Findings: Two themes described the nature of nursing-midwifery relationships: tension and teamwork. Tension existed in philosophic approaches to care, definitions of safe practice, communication, and respect. Teamwork existed when the midwives and nurses worked in partnership with the woman to develop a plan of care. Changes were brought about to improve the midwife-nurse relationship during the conduct of the study.

Conclusions: Midwives and nurses experienced day-to-day challenges in providing optimal care for childbearing women. The power of effective teamwork was profound, as was the tension when communication broke down. Failure to include nurses resulted in impaired translation of evidence into practice. All stakeholders in birth practices and policy development must be involved in future research in order to develop effective maternity care models.

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Dawley's (2002) history of nurse-midwifery in the United States (U.S.) suggests persistent differences of opinion about best maternity care practices and roles within health care teams. She states, ". . . one of the major tasks facing U.S. nurse-midwives is the need to redefine their relationships with [nursing] . . ." (p. 752). Most midwives in the U.S. are certified nurse-midwives (CNMs) formally prepared in two disciplines, nursing, and midwifery (Varney, Kreibs, & Gegor, 2004). The philosophy of midwifery according to the American College of Nurse-Midwives (ACNM, 2004) honors the normalcy of women's lifecycle events. Specifically it calls for (a) watchful waiting and nonintervention in normal processes; (b) appropriate use of interventions and technology for current or potential health problems; and (c) consultation, collaboration, and referral with other members of the health care team. As midwives enter practice they can find themselves straddling nursing and medicine in the challenge to create their own niche in health care. Part of this challenge may reflect different philosophic approaches to maternity care, not only with medicine, but also with nursing.

Kennedy, Levi, and Kane Low's (2006) metasynthesis of qualitative studies of midwifery practice identified midwives' conflict with the majority of maternity care providers who view birth as risky versus their own perspective of birth as a normal, physiologic event. Although the conflict was most often noted between midwives and physicians, registered nurses (RNs) were also found to sometimes disagree with the midwifery approach to patient care. These findings imply that maternity care within modern health care arenas is complex and requires further understanding of how members of the health care team work together to care for women. This ethnography focused on midwifery practice in an urban tertiary setting in an endeavor to understand some of those complexities. This article specifically presents data that portrayed the relationship of CNMs and RNs and their work on the same unit to provide maternity care services.

Background and Significance

The profession of midwifery has had an undulating history in the U.S. (Dawley, 2002; Varney et al., 2004).

Currently most midwives in the U.S. come from nursing backgrounds and are certified through the American Midwifery Certification Board (AMCB). The profession has grown steadily over the past 40 years, with midwives attending 11.2% of vaginal births in 2004 (Martin et al., 2007). However, the rise in CNM attended births is beginning to plateau and the number of ACNM accredited midwifery education programs declined by 14% in the past decade (Carr, 2006). The number of certifications granted declined from 587 in 1997 to 280 in 2004 and fewer nurses are entering the profession of midwifery (B. Graves, AMCB, personal communication, April 23, 2006). This is a concerning trend and requires inquiry on multiple levels.

Studies of midwifery have primarily compared their outcomes with their physician counterparts. CNM outcomes have been as good as or better than physician outcomes when maternal risk is controlled (Harvey, Jarrell, Brant, Stainton, & Rach, 1996; MacDorman & Singh, 1999). Harvey et al. (1996) conducted a randomized controlled trial comparing nurse-midwifery care of low risk women to that of obstetricians and family physicians. Cesarean birth rates were 4% in the CNM group compared with 15.1% in the physician groups. MacDorman and Singh (1999) investigated all singleton births in the U.S. in 1991 for the Centers for Disease Control and Prevention (CDC). After controlling for medical and social risk factors they found a 19% lower risk of infant death and a 33% lower neonatal mortality rate for those mothers and infants attended at birth by a CNM when compared with a physician. However, these studies fall short in explaining the reasons for the differences. There has been little research linking specific midwifery care practices to maternal and infant outcomes.

Midwives purport adherence to a philosophy of care that emphasizes pregnancy and birth as normal physiologic processes (Kennedy, 2000). That philosophy of care is known as the "midwifery model of care." However, most midwives (97%) attend births in hospitals (Martin et al., 2007) where care has become increasingly technology-based. From 1994 to 2004 women giving birth for the first time experienced a 41% increase in cesarean birth. The total cesarean birth rate is 31.1% of all births, which is the highest ever reported in the U.S. (Hamilton, Martin, & Ventura, 2007) and the vaginal birth after cesarean (VBAC) rate has dropped precipitously. VBAC rates now range from 7.9% to 12%, depending on the state (Martin et al., 2007). How do midwives factor into these statistics? How does the increasingly technologic birth environment affect their ability to practice? And, how do midwives' relationships with other maternity care team members influence their ability to practice a midwifery model of care?

There are few studies examining working relationships between nurses and midwives. Scoggin (1995) studied how CNMs defined their occupational identity and differentiated it from nursing and medicine. Although advocacy was a role for both nursing and midwifery there was a distinct difference for the midwife, which included protecting patients from technologic intervention. Scoggin identified a more difficult relationship between nurses and CNMs compared with CNMs and physicians. She found nurses often did not understand midwives' training or role and sometimes felt displaced and resentful, which could result in sabotage against the midwives. Scoggin interpreted her findings to mean that some of the conflict may be due to disagreements about the management of labor and birth, noting that CNMs would often try to avoid technologic interference in the natural process, which might be seen by some nurses as dangerous.

The philosophic differences between nurses and midwives may be related to their roles and practice experiences. Midwives are schooled in normal birth and autonomous practice and often care for lower risk women, thus they may be more trusting of the physiologic process of birth. Nurses are more likely to be in a position where the physician gives the ultimate care orders. If the institutions' culture or policies promote routine use of birth technology (e.g., continuous electronic fetal monitoring) for all low risk women, then nurses' experience with minimal technology to assess maternal and fetal well being will be limited. Nurses are also more likely to care for women across a spectrum of risk, thus their perception of the safety of birth may be colored by these experiences. Regan and Liaschenko's (2007) study of nurses' responses to a neutral photograph of a woman in labor found that "nurses' beliefs about childbirth and risk form a logic of reasoning that directs nursing actions along trajectories that might be associated with cesarean section" (p. 622). Nurses who framed birth as risky (either potential or actual) were more likely to use routine continuous electronic fetal monitoring. The authors noted this practice often leads to more invasive strategies for pain management and would be more likely to lead to higher rates of surgical birth.

Sleutel, Schultz, and Wyble (2007) conducted a qualitative study of intrapartum nurses who cited

institutional practices, poor staffing, outdated medical policies, and women's desires for increasing technology as hindrances to their ability to support women in noninterventive birth. Nurses cited CNMs as providers who stood out in being able to work with them to achieve nonintervention.

This review suggests that the culture of birth care in hospital settings is complex, with relationships among the various providers who care for women an important part of the equation. Research is crucial to explore how the complexity of birth unit culture, including the relationships among the maternity health care team, affects women's care. Deeper understanding of the cultural context of practice can provide knowledge on its influence on birth outcomes.

Method

Design

This study was ethnography focused on the practice of midwifery within an urban teaching hospital. Ethnography is the study of culture and is well suited to developing knowledge about complex societies (Foley & Valenzuela, 2005). This method was chosen specifically because it permitted the researcher to observe and experience the inner workings of a well-established and seasoned midwifery service within a complex organization. The study received University ethical approval and participants signed informed consent before individual interviews.

Sample and Setting

A midwifery practice in a large urban teaching hospital (midwifery and medical students, obstetric residents) in northern California was chosen because of its stability and its unique care models, including traditional and group prenatal care. The setting serves a primarily Medicaid-eligible population and most births are with monolingual Latina women. Data were collected over 2 years through participant observation in the intrapartum unit, clinics, meetings, and through interviews with perinatal patients, nurses, physicians (obstetrics/gynecology), and CNMs. This paper reports specifically on observed nursing and midwifery interactions and relationships and in-depth interviews with 11 CNMs and 14 RNs. For this study "midwives" refers to CNMs and "nurses" refers to RNs. Table 1 provides an overview of the characteristics of the sample.

The Birth Setting

The in-hospital birth unit is comprised of 4 labor triage beds, 7 labor/delivery/recovery rooms, 12 postpartum/antepartum beds, a 2-room operating suite, and a 24-bed regular and intensive care nursery—all contained in one wing of the hospital. The midwives attend approximately 40% to 50% of the births (600/year) and the resident physician staff attends the remaining births. The midwifery total cesarean rate is 15% and the physician rate is 22%. There are morning and evening reports in which the resident staff hand off information at their change of shift and in which the midwife discusses her or his caseload on the unit. There was minimal nursing participation at this report during the time of this study. There are usually three to four residents, one attending physician, one midwife, and one midwife student in house per 12-hour shift. There are usually eight nurses on each 8-hour shift who provide one to one care when a woman is in active labor; otherwise they may have two laboring women who are less active. There is one nurse in charge of the unit during the shift and usually one assigned to manage the triage beds.

Data Collection and Analysis

Field notes were recorded on observations of care. Observations were conducted in the birth unit over several years, including following 5 women participants through prenatal care to postpartum. Observations lasted from 4 to 8 hours and were timed to include all shifts, weekends, and handoffs at change of shift. Field notes recorded observations of the setting, personnel, and interactions of staff with one another, as well as with women during labor and birth.

In-depth interviews lasting from 30 to 90 minutes were conducted starting with broad questions and proceeded to in-depth exploration of salient issues raised by the informants and theoretical sampling of themes identified in the analysis. Specific questions for the midwives centered on their practice, their views on normal birth, and factors that facilitated and/or hindered their ability to support women in birth. Nurses were queried about their experience as an intrapartum nurse, their experiences in working with midwives, and factors that fostered or detracted from their relationship with midwives. All participants were specifically asked to provide examples and narratives to illustrate their experiences. Follow-up clarification for the interview data were obtained during subsequent field observations.

Interviews were conducted and recorded individually and in some small groups by the principal investigator (PI) who is a CNM (author 1) and a former doctoral student who is a perinatal clinical

nurse specialist (author 2). This added to the rigor of the study because both nursing and midwifery orientations were represented. Both authors had experience with the unit. The first author had worked occasionally as a per diem midwife on the unit, but her role was primarily seen as a researcher by the staff. The second author, who served as a research assistant, was conducting her own study as a doctoral student on the unit on perinatal nursing practice. The authors met frequently throughout data collection and analysis, and reflexively considered how their personal experiences might interact with their observations and analysis. Interactions with the study participants and length of time involved on the unit indicated a strong level of trust with all of the professional and nonprofessional staff with the researchers.

Qualitative analysis of the data occurred throughout the conduct of the study. Data were deidentified for confidentiality purposes, transcribed, cleaned, and entered into Atlas.ti (Version 4.2), a qualitative software program that aids in the organization, management, and analysis of large data sets. Data were coded, interpretative memos recorded, and thematic analysis was conducted. Rigor was assured through participant validation and interpretative consensus during research team meetings. The findings were shared with both nursing and midwifery staffs who provided validation that it reflected their experience. The manuscript was reviewed by representatives from both nursing and midwifery groups who participated in the study.

Findings

Two overarching themes, tensions, and teamwork, characterized the relationship between nurses and midwives. Tensions were centered on the relationship between the nurses and the midwives as they worked within a complex organization to provide care for childbearing families. The relationship between nurses and midwives became tangled around differing philosophies about labor and birth, safety, communication and respect, and pain management. Teamwork was sometimes experienced and other times longed for, specifically in relation to how to provide best care for women. The findings will be presented by major thematic foci and discussed from nursing and midwifery perspectives. Comments from interviews are noted in parentheses at the end of the quote. Comments obtained during field observations are noted as such at the end of the quote.

Table 1: Characteristics of Nurses and Midwives

	Mean	Range	*SD*
Nurses (*N* = 14)			
Age	44	31-58	9.6
Years as a nurse	17	2.5-39	12.3
Years at birth setting	10	1.5-25	8.5
Years in obstetric nursing	8	1.5-25	7.6
Educational preparation, *n* (%)			
Diploma	2 (15%)		
Associate degree	1 (7%)		
Baccalaureate degree	7 (50%)		
Masters degree	3 (21%)		
Declined to report	1 (7%)		
Midwives (*N* = 11)			
Age	50	33-64	8.7
Years as a midwife	18.5	7-27	6.5
Years at birth setting	13	4-21	6.7
Educational preparation in midwifery, *n* (%)			
Certificate/Masters	2 (18%)		
Direct entry/RN to masters[a]	4 (36%)		
Masters (prior RN experience)	5 (46%)		

Note. [a]Students enter with degree other than nursing. Prepared first in nursing and progress directly to masters degree in nursing with preparation in midwifery.

Tensions

Philosophic Tensions

The midwives experienced multiple conflicts while striving to assist women to achieve normal births with minimal technologic intervention. Conflict was situated within a setting where midwives believed their colleagues, including nurses and physicians, did not necessarily share their philosophy of caring for women during labor and birth. Coping with conflict was a daily process of midwifery practice and teaching. The midwives felt that many nursing routines prevented their ability to promote normal birth. The issue of intravenous (IV) access was one exemplar on the interpretation of safe practice during normal labor and birth. Some of the midwives noted that women sometimes had IVs placed without a specific order. "But if, if I was a woman in labor, and I'm wandering around with an IV pole, I'm not going to feel as if I am really doing something totally normal . . . there are so many women who are just essentially totally normal who I don't feel are given the freedom to, to really labor . . . and

The relationship between nurses and midwives became tangled around differing philosophies about labor and birth, safety, communication and respect, and pain management.

that, that's a shame" (Midwife/interview). Some of the nurses thought it simply was not safe to have a woman labor without IV access. Others said it was not necessarily unsafe, but that "IF" the woman happened to hemorrhage, placing an IV during the chaos was the last thing they wanted to think about—it was long range planning. One nurse jokingly compared it with "Murphy's Law" in which a woman would be more likely to bleed if an IV was not placed ahead of time. Another said, ". . . and it's scary for me, is when they don't want, they don't want to start a saline lock. Some midwives they're like, 'No, no, no, she's fine. She's- everything is normal.'" (Nurse/interview).

Although the midwives expressed the presence of philosophic conflict about normal birth, they did not observe it in all of the nurses. "The one great thing about the nurses [here] is there's a huge pod [informal group] of them who completely believe in normal birth . . . and then there's another pod that don't" (Midwife/interview). The nurses also judged the midwives when they were not practicing in accordance with midwifery philosophy. This happened when the midwives were too busy to 'labor sit' with women because they had a high volume of laboring women on the unit. ". . . Well, it really is really simply just that they would stay longer . . . they all have the skills and the compassion to be in there and—and help the women. But because either they're too busy or they have students, they don't . . . or sometimes they're just out talking at the desk, you know, and I go out and I think, 'Why aren't you in there?' " (Nurse/interview).

Some nurses felt they were placed in the 'bad guy' position because they had to enforce certain policies; other nurses believed they were sometimes prejudged about their philosophic beliefs. "I feel like a lot of times there's sort of an assumption that the nurse is coming from a really different place in terms of their philosophies . . . I don't think they often realize that I'm actually on the same wavelength, that we're not sort of fighting with each other . . ." (Nurse/interview).

While the study was taking place the midwives began to insist that the nurses use intermittent auscultation (IA) of the fetus on low risk women in labor, citing evidence to support the change. The nurses felt there was minimal interdisciplinary discussion before implementation of the policy and tense, heated interactions ensued, eventually bringing about professional mediation over the issue. The concerns expressed by nurses were about the impact on staffing demands and perceived safety of IA. "I feel like a lot of the midwives don't understand or respect what it is that the nurse is sort of required to do in this setting . . . I guess I don't like being asked not to do things that sort of by my own professional standards and guidelines [re: IA] . . . so that's more I guess where I've had conflict" (Nurse/interview). The midwives, on the other hand believed the nurses were unwilling to accept a change the midwives believed was rooted in scientific evidence. "They use a monitor to do auscultation, but then they leave it on for two hours, and um it drives me nuts . . . you know, and a lot of nurses aren't comfortable with it [IA], even if you educate them that it's a very valid way of doing things. It really, really frustrates me" (Midwife/interview). Observations on the unit and during mediation sessions indicated a marked disparity in perceptions of what constituted safe and achievable practice for ongoing assessment of fetal wellbeing.

Tensions about Communication and Respect

Issues about communication and respect were voiced by both groups. Many nurses noted that they expected different things from midwives than they did from physicians. Some felt a sense of oppression and that midwives were sometimes seen as the oppressors. Both groups felt they had balancing acts and had to be creative to achieve their ends. For the midwives it meant getting physicians to respect their plan to delay interventions in order to let a woman's labor unfold on its own. For nurses, it was respecting the difficulty of their jobs and their juggling of many tasks. "It's hard for me when a midwife comes out of triage and says, 'Can you get the patient juice?' And I'm like, '. . . you're a midwife! You're supposed to have this whole like holistic view to your patient . . . And it's clear I'm running,' I'm like, 'You can't go get your patient juice?' But interesting, I don't have the same expectation of the doctor (smiles)" (Nurse/interview).

Nurses talked about feeling invisible—neither acknowledged nor considered a viable part of the team; occasionally they described themselves as the handmaiden. When this "taken-for-grantedness" came from the midwives it was more painful because CNMs are nurses. "There are midwives that walk into the room and don't even acknowledge the nurse. They go right to the patient. And,

you know, rightly so, but there's no like folding in the nurse . . . Am I redundant?" (Nurse/interview). This implies tension over the roles of caring for the woman, with potential overlap and a disregard for nurses by midwives. The nurses seemed to accept the latter from physicians, but found it intolerable when it came from the midwives who were of the same roots.

Some nurses did not feel the midwives understood their scope of practice or their constraints, especially documentation issues and staffing challenges. One nurse described an altercation over not having enough staff to support a plan of care the midwife wanted to implement. The midwife challenged the nurse's rationale for her decision and the nurse described her anger. "And I flipped out. I flipped out! [lowers voice for emphasis]. And I said, you know, 'You don't know anything about my job!'—and I walked away from her" (Nurse/interview).

At the same time the midwives perceived behavior from the nurses that was disrespectful to them as providers. During the study tensions between the nurses and midwives came to a head and the two groups employed a professional mediator to help them work through the issues, many of which were about communication and respect. One midwife expressed chagrin at her lack of sensitivity when it was pointed out to her. "Why would I not know that? I've been a midwife a long time and this really hit me hard. [Nurse] said, 'Sometimes you all are so focused on your patient you treat RNs like shit.' I admit, sometimes that's true" (Midwife/field notes).

Tensions Over Pain Management

Working with a woman's labor pain was another point of contention. Midwives sometimes felt sabotaged, and nurses felt like they were caught in the middle. This seemed to stem from different philosophies about what was best for women and the role of pain in labor. The midwives were noted to be extremely busy during many of the observed shifts, sometimes with two or three women in labor and postpartum rounds to conduct. At other times they may have had only one woman in labor, but had competing teaching or administrative demands. This meant that they could not always 'labor sit' the woman and relied on the nurse for bedside care. When this happened communication about pain management sometimes broke down. Nurses felt they knew what the woman was experiencing with her pain better than the midwife. ". . . And I tell the patient, you know, I have to kind of like coach them.

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'If you really want medicine, I've talked to her and she thinks you don't need it right now. But if you want it, it's your right,' you know" (Nurse/interview). However, midwives often had knowledge gained during prenatal care, or during her interactions with the woman about her desires for pain management. They felt nurses did not understand that or worked against them. ". . . and I found out that every time I was walking out of the room, the nurse was undermining what I said. And so the patient was caught in the middle . . . and it ended up that the patient got the epidural without me knowing—and I just felt so betrayed and so angry. I didn't handle it the best [laughs] 'cause I sort of blew up when I found out she did that.' But I was just like, 'Oh my God! You- you totally don't trust me'" (Midwife/interview).

Tensions over philosophy, respect, communication, and pain management emerged as central to the differences between the midwives and the nurses. However, there were also examples of similarities and collaboration in care. The other major theme was teamwork, which when it worked, could be highly effective.

Teamwork

Working Together for the Woman

There were examples of excellent teamwork and the difference was palpable when midwives and nurses were involved equally in the care plan, respected each others opinions, and communicated effectively. ". . . there was time to sit and really brainstorm about what would work best for this patient . . . the midwife was really committed in that situation to helping the patient have what she wanted . . . and you know, working collaboratively with the nurse" (Nurse/interview). Even with the considerable tension, more than half of the nurses said that they were glad the midwifery service was present and would refer women to them for their maternity care. "I'm glad they're here. I'm glad they're here. I really am. I'm- I'm happy that I get this opportunity to work with them because it kind of balances the high-risk population we have. They kind of reassure that having a baby is this natural thing, healthy, happy, experience for people" (Nurse/interview).

Commitment to Teamwork

Teamwork was both described as an ongoing process and as something that could be improved.

One nurse talked about how she and the midwives would work with each other to give the care the woman needed, even though they had other demands on their time. "It's like, 'I'll sit here with you at the bedside and push as long as I can and then I'm gonna have to go out and do something for a while' . . . I had this funny period where I came back [from maternity leave] . . . pumping, you know, new baby, sleep deprived, need to eat, need to pump. And so the midwives would gladly sit and be with a patient for me for fifteen minutes while I did those things. And I always really respect that" (Nurse/interview). However, there were also comments that the team needed more building, more strength. "So we're a team . . . and the midwives are no smarter than the nurses, but we have different strengths. And to bring it all together . . . I mean, if it would ever actually really come to fruition, that'd be amazing" (Nurse/interview).

The commitment of nurses and midwives to working together and improving their relationship was perhaps best illustrated during their mediation sessions. Shortly after the combined groups of nurses and midwives gathered in a conference room one of the midwives arrived a few minutes late, but before the session had formally started. Sensing tension in the room she quipped, "Is this the suicide prevention group?" Another answered back, "No, this is marriage counseling!" Both groups dissolved into laughter. As the discussion started both nurses and midwives talked about their long time association with one another, shared memories, and expressed concern that they get back to a more trusting relationship. (Field notes, mediation session).

Teaching Midwifery

Teaching by the midwives was commented on by some of the nurses and was valued, especially about specific techniques or approaches in helping laboring women. One midwife was mentioned several times as one who "loved to teach." Specific instances of nurses sharing their knowledge with the staff midwives were not observed.

It was evident that the nurses were active in teaching student midwives, sometimes covertly. "I've learned a tremendous amount from just hearing them [midwives] teach their own students . . . I've been able to say to the students, 'Okay, she's gonna come in now. She's gonna ask you what you should do . . . the answer should be that you're going to straight cath . . .' I've learned enough in advance to be able to coach the students to give the right answer. And it always is the right answer, you know (smiles)" (Nurse/interview). Yet the involvement of student midwives on the team was sometimes troubled. Many of the nurses felt students lacked respect for the nursing role and some identified behaviors in which the student placed blame on the nurse when questioned by the preceptor about her actions. "And the student said, 'Well, the nurse didn't tell me.' So- boy, did I become savvy to them really quickly, you know" (Nurse/interview). Some of the midwives noted that the nurses tested the students and often distrusted ones with minimal nursing experience. Student midwives clearly added to the complexity of effective teamwork.

The findings of this study were evaluated by the maternity team leadership to explore the development of a more effective team approach to birth care. As the primary author outlined future plans to the nursing staff for a participatory action research study she mentioned that it would be important to include all providers of birth care (nurse, physicians, midwives, students, and doulas). One of the nurses who participated in the study looked at her with a stunned expression and a bit of sadness and said, "I've never been referred to before as a provider" (nurse/field note). This comment conveyed a sense that the nurse was an accessory to the team and not a major player, reflecting the instability of the "team" concept from a nursing perspective.

Several things happened as a result of this study for this particular birth setting. The nurses and midwives began to talk more about how to care for women. They agreed that pain assessment in labor needed exploration, and nurses noted during the feedback phase of the study that pain management issues had improved considerably. The study revealed how stretched the midwives were to cover a busy service and how this affected their ability to practice a midwifery model of care. They have added an additional midwife during the morning to cover postpartum care. The nurses and midwives have developed a monthly journal club. Finally, the nurses asked the midwives to become a part of the formal orientation for new nurses to explain their model and philosophy of care.

Discussion

The relationship between midwives and nurses in this study had its strengths and challenges. One of the differences that both groups struggled with was about pain management. The differences described by the participants in this study suggest that women can be caught between the providers'

philosophic conflicts and struggles, rather than being the focus of care respectfully centered upon their individual needs. When the findings of the study were presented to the nurses, they brought up the difficulties with the pain assessment tools they have to conduct at regular intervals for hospital accreditation purposes and their inadequacy in assessing the pain of labor. Differing expectations, knowledge, and resources can seriously hamper a woman's access to optimal pain relief (Rooks, 2007). Too often because of lack of skills or alternative options women choose an epidural, when they might have been able to avoid the risks associated with this analgesic approach if other options had been available. It is a disservice to women if they are encouraged to have a normal birth and then are not provided skilled and supportive care (Kennedy & Shannon, 2004). Klein, Sakala, Simkin, Davis-Floyd, and Pincus (2006) noted that women who are afraid about the safety of their baby become vulnerable and dependent in their decision-making. Too often, that fear is misplaced and results from misinformation or inadequate assessment of coping.

One of the current quality measures in health care is the application of evidence into practice (Enkin et al., 2000). Although this study did not specifically set out to explore how evidence was translated into practice on this birth unit, this became a predominant topic that highlighted philosophic differences between nurses and midwives. During the course of this study the midwives requested IA be conducted on low risk women. They presented supporting scientific evidence, but the nurses perceived it to be brief with no discussion on the impact it would have on the nursing staff. This precipitated a major breach between the two groups and IA is now conducted sporadically. In effect, failure to include nurses resulted in impaired translation of evidence into practice. The way IA was implemented may reflect some blindness on the part of the midwives to the role of the nurse and the impact of practice changes on workload. The idea that changes in practice can simply be "ordered" and taught rather than negotiated and mutually agreed upon reflects a power differential that does not recognize the nurse as a legitimate stakeholder and full partner in the care of childbearing women, as suggested by the nurse who mentioned she had never been referred to as a provider of care. Thus the difficulty translating IA evidence into practice may have been less a conflict about the use of IA and more about whether nurses were truly recognized and valued as *contributors to* rather than just *implementers of* the plan.

Changes in practice cannot simply be ''ordered'' and taught; they must be negotiated and mutually agreed upon.

Although the evidence supports that continuous electronic fetal monitoring does not improve birth outcomes (Alfirevic, Devane, & Gyte, 2006), a survey of 1,575 U.S. women who gave birth in 2005 found that almost all (94%) experienced some form of electronic fetal monitoring and for 76% it was continuous; only 3% had intermittent fetal monitoring. Most (83%) had an IV and 76% received an epidural during their labor (Declercq, Sakala, Corry, & Applebaum, 2006). In our study many of the nurses were uncomfortable with IA because of concerns about litigation risk and impact on nurse staffing, because IA requires intensive one-to-one nursing support. Graham, Logan, Davis, and Nimrod (2004) found similar concerns in their Canadian study on the implementation of IA and increased labor support. Effective change was influenced by nursing and medical leadership, medical-legal concerns, and tailoring the intervention to address potential barriers in the setting. These findings are interesting and represent some of the challenges to normalizing birth (Downe, 2004).

Evidence suggests that supportive care for women is associated with excellent outcomes (Hodnett, 2000). This could be achieved in concert with the support required to effectively monitor women with IA, thereby combining two areas of evidence for implementation in practice. Future research could capitalize on both of these issues and potentially help to decrease the rising cesarean birth rates in the U.S. This is supported by a recent meta-analysis on strategies to reduce cesarean rates (Chaillet & Dumont, 2007). The authors found that most effective strategies included the involvement of health professionals in the analysis and modification of their practices and the importance of identification of barriers before implementation of interventions. Recent research findings suggest that a comprehensive interdisciplinary approach to application of evidence, strategies to improve teamwork, and active participation of front line providers can be highly effective in improving the quality of care (Funai et al., 2007; Pronovost et al., 2006), and that sustained changes in unit teamwork culture can improve outcomes in perinatal care (Funai et al., 2007; Rochon et al., 2007).

Midwifery care is associated with excellent outcomes, yet the pool of future midwives is declining and the future of midwifery is dependent on a cadre of bright and energetic students. Could it be that

nurses do not see the profession as appealing? Do midwives respectfully reach out to nurses and value their membership on the maternity care team? Do midwives help nurses understand the reasons for their specific approach to birth care? The discussions in this study suggest that relationships between nurses and midwives are strained and could influence a nurse's desire (or lack of) to step into the midwifery profession. This was not specifically explored in this study and should be a goal for future research.

This study was limited by its conduct at one birth setting with only one midwifery practice; the results are not applicable to all midwifery practices or birth settings. However, it does reflect a challenge faced by many U.S. midwifery services; that of being asked to attend more than one woman in labor and the inability to provide the kind of care associated with midwifery philosophy (McCloskey, Kennedy, Declercq, & Williams, 2002). Strengths included prolonged engagement, triangulation of data collection, and participant validation of findings (Polit & Beck, 2004). In addition the method allowed close observation of midwifery practice in a busy tertiary setting.

Nurses are the frontline providers of birth care in the U.S. for most women. This study confirms the frustrations observed by other nurses in their challenges to support women in intrapartum care (Sleutel et al., 2007). Nurses, because of their sheer numbers, probably hold the greatest potential to influence the culture of birth in the U.S. and we challenge the professions of nursing and midwifery to work together toward normalization of birth and to stem the tide of rising birth technology. This requires nurses and midwives to work as partners.

Conclusion

This is one of the few studies in the U.S. that has examined the relationship between nurses and midwives and provides insight into the complexity of providing care to childbearing women in a busy tertiary setting. It required courage and commitment of both midwife and nurse participants as they shared their experiences and the authors acknowledge their participation gratefully. Both groups worked with different and similar stressors and both wanted to provide good care. Their comments provide a glimpse of the day-to-day challenges of implementing evidence-base practice such as IA, the difficulties faced when communication falters, and the power of effective teamwork. The changes noted in this birthing unit support the potential for future participatory action research in birth settings. Future research should join all stakeholders in birth care, including women to explore challenges and facilitators to providing highest quality maternity care. This research should examine how evidence is translated (or not) into practice, and how translation is specifically facilitated or hindered. Through increasing our understanding of how maternity care teams practice most effectively together "with women" we stand to improve care and outcomes.

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