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Practicing What We Preach? A Study Of The Implementation Of Exemplary Midwifery Process In Clinical Education

Ginette Lange
Seton Hall University

PRACTICING WHAT WE PREACH? A STUDY OF THE IMPLEMENTATION OF EXEMPLARY MIDWIFERY PROCESS IN CLINICAL EDUCATION

BY

GINETTE LANGE

Dissertation Committee

Martin Finkelstein, PhD., Mentor
David Gibson , EdD
Elaine Walker , PhD.

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Often one engages on a journey with little idea of when the ultimate goal will be reached. Through the many forks in the path where no clear road signs nor directions are provided , one makes many confused and often baffling choices.

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CHAPTER I

INTRODUCTION

Background to the Problem

Professional Higher Education has a long and vigorous history in America. Already in the middle part of the nineteenth century, The English model of liberal arts college was giving way to an institution of higher learning more involved in the teaching of subject matters that could be of 'use" to this young colony. The teaching of the professions has since then been an integral part of the university albeit the subject of frequent concern.

Professional teaching usually involve not only a theoretical knowledge, but also a more practical, skill-oriented aspect, where application of the theory to "real life" situation are practiced under some supervision, or mentoring. The development of the field of teachers education have parallel other professional education including, nursing and midwifery in many regards. All three are service oriented with part of their curriculum taught by faculty expert in their respective discipline and part by practitioners in the "fields". In keeping with the "caring " aspect attributed to all three an endowment with a somewhat lower academic status has prevailed and accounted for the lack of empowerment and self-esteem of members of all three professions (Bateson, 1989, Noddings, 1984,).

As in midwifery practice teaching, it has been acknowledged in teachers education that a theory-practice gap exists between classroom theory and the practice that currently exists in the schools. (Johnson 1990) . Professors of education are caught between the traditional scholarship and research norms of higher education and the technical demands of practitioners. (Dicks , 1999).

It is an undercurrent feeling that inside many school of education, the teaching of classroom teacher is given little prestige and mostly relegated to entry level work. The responsibility for tutoring/mentoring novice teachers is given to the most junior faculty with the desastrous results that one in six education professors has never really taught in either an elementary or secondary school. This created a large gap, a non congruence between what is taught in the classroom as theory and the skills needed for successful practice (Gregorian , 2001).

As a profession also taught in institution of Higher Education, midwifery reflected upon its need to participate in higher educational endeavors while at the same time maintaining a strong and creative practice curriculum. Little research has been done , however, on clarifying to which extent its clinical education reflected the teaching done in the classroom.

Defining nurse-midwifery as a profession is superficially an easy task. The term "midwife" conjures images of maternity and more specifically of "assisting in childbirth". The reality, however, is much more complex. Nurse-midwives do care for women during pregnancy , childbirth and the postpartum . So do obstetricians, in what seems to be the same capacity. Nurses and nurse practitioners, also compound the picture , being present by the mother's side during the prenatal care and the birth of the baby .

Scope of practice is better delineated: obstetricians are surgeons, nurse- midwives limit their skills to normal pregnancy and birth, "normal" as precariously defined by both professions. Both nurse-midwives and nurse practitioners share with physicians the care of women with minor complications . Nurse-midwives do most of their work in hospitals, just as obstetricians do. Most nurse-midwives are women, (over 95%) while most obstetricians are male. The gender gap is rapidly closing, though, with women now outnumbering men enrolled in medical school.

In 1977, the American College of Nurse-Midwives (ACNM) defined the nurse-midwife as a an " individual educated in the two disciplines of nursing and midwifery" (Rooks 1997, p. 69). This statement segregated as well as related midwifery to nursing. It did not, however, endowed nurse-midwifery with a clear identity. When asked to define their professional identity as a continuum between midwifery-nursing-medicine, most nurse-midwives chose "midwifery" as a commitment to professional identity (Scoggin, 1995)

The World Health Organization (WHO) has developed a definition of a midwife which, after some revision, was adopted by the International Confederation of Midwives (ICM) in 1972, accepted by the International Federation of Gynecologist and Obstetricians in 1973, and finally revised as follows in 1990:

> A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (Rooks , 1997, p. 6)

The ICM further expand on the required "skills" that must be demonstrated by the midwife:

> She must be able to give the necessary supervision , care and advice to women during pregnancy , labour, and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. (Rooks , 1997 , p6) ·

The development of midwifery in the United States has paralleled the country's multicultural origins. Immigrants brought with them their own midwives, some from a well educated , professional background, some others less educated, "granny" midwives. Since all bear the same name in records, it is very difficult to distinguish one from the other. Certified Nurse Midwives (CNM) , originally public health nurses with advanced education in midwifery were integrated in the Health Care system as an answer to high infant /maternal mortality at the beginning of the XXth century. Registered Public Health Nurses, with experience in maternity and willing to continue their education, were instructed in the skills of normal labor and delivery, in immediate newborn care and in infant health and development. The program was immensely successful in lowering maternal/infant mortality . This did not represent a landslide success into professional empowerment . Slowly, over the years, through much perseverance and assertiveness , nurse-midwifery developed a recognized albeit still contested niche . Nurse-midwives are now licensed to practice in all 50 states and the District of Columbia and are certified

through the Certification Council of the Board of the American College of Nurse Midwives .(ACNM/ACC) More than 7, 000 Certified Nurse-midwives are member of the ACNM, and more than 5,700 are currently in clinical practice in the USA (ACNM 2000).

In 1999, the most current year data is available through the National Center for Health Statistics (NCHS) , there were 287,288 CNM-attended births in the U.S.. (ACNM 2002) . The number of CNM-attended births has increased every year since 1975, the first year that the NCHS started to keep data. Most CNM-attended births (96%) occur in hospitals, Community hospital or Perinatal Centers. Nurse-Midwives also attend births in Free Standing Birth Centers (2.4%) and in the Home of the patient (1%)

It is now possible , under certain condition, to attend midwifery school and become a Certified Midwife (CM) without being a nurse. The ACNM recognizes and grant certification to such professionals, after they have successfully passed its certifying examination. Other midwives , such as Certified Professional Midwives (CPM) have continued to practice outside of the medical establishment and have now organized into a professional body with standards and competency examinations. The process is controlled under the North American Registry of Midwives (NARM). In most states the Professional Midwives practice in the homes . It is very difficult to obtain clear statistics on their practice, due to their illegal professional status in many states.

The sheer number of practitioners claiming a part in the practice of birth attendant has greatly complicated the role definition of the Nurse-Midwife and since the beginning in the 1920's, when public health nurses started to be educated as midwives with the goal of improving under-served urban and rural maternal outcomes,

nurse-midwives have had to struggle for a professional niche.The struggle has continued, waxing and waning but nevertheless present. Today , in the unstable health industry, it has become critical.

Survival as a profession hinges on important parameters, the first, : A well-defined scope of practice, ability of self governance and independent decision making.

Professions are characterized by " a prolonged specialized training in a body of abstract knowledge , and a collectivity or service orientation" (Goode, as cited in Freidson, 1975 p. 77). The other characteristics mostly refer to autonomy (standards in education and training), recognition by government (licensure), and freedom from lay evaluation (self governance). How specialized ought the training be to truly qualify as professional is matter of debate, but the truth remains that the more specialized and unique a body of knowledge, the more mystery and secrecy attached to its training and practice, the more autonomous its internal management , then the more vitality and power will result. (Freidson, 1975; Larson,1977)

This privilege of freedom from the control of outsiders is justified by the claim that professional work entails a high degree of skill and knowledge, and that professionals demonstrate a high level of selflessness and responsibility. (Freidson & Buforrd,as cited in Medical Work in America 1989, Freidson,) It is clear from reviewing the literature from the sociology of the professions that the identification of a specialized body of knowledge is essential to the survival of a profession and its right to self-determination and autonomy.

Survival as a profession is also achieved by transfer of knowledge and socialization through professional education .There are currently 47 ACNM accredited

nurse-midwifery education programs in the U.S. Most of these programs offer a master's degree. Programs vary in length from 12 months to 3 years, depending on the preparation of their registrants and the degree they confer. All accredited programs offer a theoretical, didactic formation, well grounded in a solid supervised clinical experience. All ACNM accredited programs, Certificate, Masters, on-site or distance, lead to the certifying exam.

Professional education has traditionally espoused the Theory- Practice hierarchy enunciated by Thorstein Veblen in the 1940's , through Schein in the 1970's. First (and more importantly) the relevant basic science has to be presented, then the applied laboratory work, and finally (and of somewhat lesser intellectual importance) the field, practicum, or clinical experience, worded differently according to the specific profession.

The Theoretical entity of the curriculum, comprised of basic sciences often has little relevance to the "applied " part of the curriculum, which deals with everyday, complex and unpredictable events. This "Theory-Practice Gap", as it is known to educators in the professions, has been the subject of much debate and tentative solutions but a paucity of research during the last twenty years. Germane to the teaching of clinical or other practical skills has been the transfer of moral values inherent to the professions, of other socializing attributes needed to transform a lay person to a true member of the profession.

Nurse-Midwifery has not been immune to this soul searching attempt at defining or perhaps re-examining the true content of clinical education. Do we practice the theory we so dearly espouse, or more do we faithfully role model it as we precept our students

through their clinical experience.? " ... I believe it is too often the case that new practitioners feel there is a contradiction between the educational goal and actual practice." (Jacobson 1993)

Donald Schon, in his book "Educating the Reflective Practitioner" (1987) describes this duality between theory and practice very vividly in the following manner:

> In the varied topography of professional practice, there is a hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest maybe, while in the swamp lie the problems of greatest human concern (Schon, 1987, p. 3)

Statement of the Problem

The dimensions of exemplary midwifery processes have been validated in a recent study by Kennedy .(Kennedy, 2000) . Congruence between those exemplary processes and those observed by midwifery students during their clinical experience has never been established, thus creating a lack of empirical data necessary to properly evaluate the efficacy of midwifery clinical education.

Purpose of the Study

The purposes of this study are to determine first, if there is congruence between midwifery's exemplary practice as process and .the espoused theory of the graduating students and second, to which extent the values of exemplary midwifery process are observed by nurse midwifery students during the student's final clinical experience (Referred to as "Integration") .

Importance of the Study

Survival as a profession as per Freidson, and others (Freidson, 1970, 1975, 1989; Larson, 1977; Coe, 1970) is dependent on the acquisition of a unique body of knowledge . "Most fundamentally, professions control the development of the body of knowledge on which their practice is based" (Rothman 1984,p. 303.) The necessity to establish a base for the "discipline" of midwifery, is imperative for various reasons, first for the newcomers to have a unifying vision, second to attempt to solve its own clinical and professional problems, and third to better maintain its autonomy faced with the increasing wish for control from powerful disciplines such as medicine. (Bergstrom ,1997) " Although there are many definitions of professions, one characteristic all have in common is that professionals do some kind of defined work that requires a certain amount of specialized knowledge."
(Bergstrom, 1997, p. 418.)

Assuming the disappearance of midwifery as a profession would mean that choices in childbirth would be curtailed, since the medical model of care would be the sole venue for women and their families . According to Rooks, (1999 a) , the approaches of both obstetrics and midwifery are complementary, with similarities, but also with important differences. Physicians are expert in pathology and should have primary responsibilities for pregnant women with diseases and complicated labors. Midwives are expert at preserving the normal. Their philosophy is different in that they espouse the belief that pregnancy and birth are normal healthy functions in a women's life. Their role is to recognize and enhance the power of the normal. Obstetrics, according to Rooks, has "expanded the proportions of pregnancies considered abnormal or pathologic by using monitoring devices that over-diagnose complications"(Rooks, 1999 b, p72) " Since an unexpected complication can happen to any woman at any time, the medical management model prepares for the worst (Rooks, 1999 b, p. 72) ." The midwifery model emphasizes the partnership between the practitioner and the patient. Its main focus is on prenatal care, where the rapport between the midwife and the mother is established. Midwives believe that knowing a mother beyond the obvious need of the pregnancy is essential to safe care. Robbing women of the important midwifery model of care choice would a deep set back to paternalistic , male centered model of medical care.

Ernest Boyer, in a keynote address delivered in 1990 at the ACNM annual meeting in Atlanta GA warns of " becoming a 'carbon copy' of a system preoccupied more with procedures than with compassion, midwifery in America will have lost its essential purpose, and the quality of maternal care will be greatly diminished" (Boyer, 1990, p.216) . Boyer also urged nurse-midwifery programs to " begin to shape a core

curriculum that defines, with clarity and coherence, the fundamentals of the profession" (Boyer, 1990, p. 219) .

The quality and availability of the care to under-served population , which has traditionally been the domain of the American Nurse-midwives will be greatly curtailed with their demise. Since their inception, at the turn of the century, midwives in America have provided care to inner city, rural, poor women and their families. In a study published in 1992 from a survey of 1989 Certified Nurse-Midwives, Scupholme et al found that "CNM,in all types of practices, are providing care to women from populations that are vulnerable to poorer than average, because of age, socioeconomic status, refugee status, and ethnicity. Ninety nine percent of CNM report serving at least one group of vulnerable women."(Scupholme, De Joseph, Strobino,& Paine, 1992 p. 344).

Midwifery has a long and well -documented history of successful outcomes within the healthcare delivery to mother –children and their families. Beginning at its inception in the first half of this century with the creation of Maternity Center Association which resulted in a drastic reduction in infant mortality , and the establishment of the Frontier Nursing Service in Kentucky in 1925 Nurse Midwives were successful at reducing maternal infant mortality to levels below that of the general population. Dr Louis Dublin, Third Vice President and Statistician of the Metropolitan Life Insurance Company Studied the first 1,000 deliveries and wrote that if the midwifery model of care were to be implemented in the entire country we would " save 10,000 mothers, 30,000 stillborn and 30,000 children at the end of the first month of life"(Rooks, 1997, p.37)

A study by Scupholme et al in 1992 suggested that Midwives, as a group , make a major contribution to the care of vulnerable populations. Fifty–six percent of women who are cared for by Nurse-midwives live in area that are designated as underserved. The result of this study also indicate that 99% of respondents serve at least one group of vulnerable women.

Nurse-midwives have made a major contribution in reducing low birth weight as well as cesarean section rate among adolescent. (Brucker & Muellner,1985; Piechnik & Corbet 1985). The cesarean section rate is alarmingly high in this country (as high as 35% in some area) for reasons that range from fear of litigation to unsuccessful outcome stemming from aggressive interventions. This trend has been a concern of epidemiologists and health policy makers because, despite this technology and interventionist approach, our infant mortality ranks 22nd amongst developed countries. Nurse-midwives were instrumental in lowering the C/section rate among low-risk patients , as describe in a study published by Davis, Riedmann, Sapiro,Minogue & Kazer in 1994 . Similarly, supportive care by nurse-midwives was associated with a reduced rate of C/section as published in the American Journal of Obstetrics and Gynecology in 1993 . Turnbull et al in the Lancet, (1996) conclude that midwife managed care for healthy women, integrated within the existing services is clinically effective and enhanced women satisfaction with maternity care.

Moving along the lines of statistical data, MacDorman & Singh (1998) concludes with this comment: "National data support the findings of previous local studies that certified nurse-midwives have excellent birth outcomes. Certified nurse-

midwives provide a safe and viable alternative to maternity care in the United States, particularly for low to moderate risk women" (MacDorman & Singh 1998 p.314)

Theoretical Framework

Espoused Theory vs Theory-in-use

Argyris and Schon, (1974) in their work on Action Research, have singled "human agent" as the designer (creator) of actions . The on-going action-design, which is conceptualized as a solution to a perceived problem, is continuously evaluated, assessed, and if necessary re-designed in relation to its efficacy in achieving the desired outcome.

The mental representation of a problematic situation and the solution designed to meet those challenges are called "Theories of Action" by Argyris and Schon. (1974) and by Argyris et al (1985) . Theory of Action is represented in two particular types: "Espoused theories" and "Theory-in-use'.

Espoused theory is the framework of belief a person lends deep credence to. For example, midwives believe that they are the experts on the view of pregnancy and birth as a normal physiologic event.

Theory-in-use, is the set of belief represented by a persons' actions. For example: midwives, in working within the health care team, often use the same protocol (medical =illness-oriented) as the medical team in providing care to their patients. Human agents may not openly admit to their "Theory-in-use" (implicit). The theory might not be evident to them, as their espoused theory is the one to which they lend profound allegiance to. A person's action is always the reflection of their "Theory-in-use", whether congruent or not with their "Espoused theory".

A previously implicit 'Theory-in-use" may be made explicit through "Reflection on action", (Schon, 1987) or when its efficacy is challenged. Theory-in-use can be tested both for internal consistency and congruency. Internal consistency measures the extent to which the actions achieve the desired goals . For example, in Nurse-midwifery, the theory of "Empowerment of the women" can come into conflict with the theory of "need to protect the fetus from harm." At some point on the continuum, there might have to be a choice as to which theory-in-use will potentially supercede.

A dilemma of incongruity is created when it becomes clear that the values expressed in the "Espoused Theory", which are central to self-esteem and professional identity are in deep conflict with the " Theory-in-use" . For example, espoused midwifery theory of "empowerment of the woman" is jeopardized in a more paternalistic -medical setting where women are traditionally being cared for by nurse-midwives . "One goes on speaking the language of one theory, acting in the language of another, and maintaining the illusion of congruence through systematic self-deception" (Aargyris & Schon , 1974, p.33)

Diagnosis of "Theory-in-use" is difficult, because most of the theory-in-use is tacit. When asked to describe their behavior, people will share their espoused theory. Argyris and Schon have used directly observable behavior as reported in verbatim interaction between protagonists, or case studies written by the participants. The format required for recording the case studies was the following: Participants write case studies on what was actually said, how they actually behaved and how other responded . Participants are asked to select one or two crucial episodes and report them in detail . Content analysis is done, and variables identified. Congruence between " espoused

theory" and "theory-in-use" can then be established. " If incongruity is intolerable, it is because the protagonist finds that he cannot realize the central governing variables of the espoused theory on which his self-esteem depends . (Argyris & Schon, 1974, p.33-34)

Espoused Theory of Exemplary Midwifery Process

The governing variables of the espoused theory of Exemplary Midwifery process have been identified in a Delphi study conducted by Kennedy in 2000. The question : "What is unique and exemplary about the midwifery model of care?" Was answered through three rounds of inquiry.

The first contact with the sample, which had been chosen through identification of exemplary practice by peers and education program directors, as well as the women they cared for, was the result of answers to open ended questions requiring written responses . The second and third rounds were developed from themes extracted from the first round and validated through a Likert scale ranking from 1-7. Items resulting in scaling greater than 6 were preserved as representing high consensus . Consensus was reached after the third round, with the following results, grouped by the author under the following three "General Dimensions"

Under the General dimension of Therapeutic:

1. Outcome Optimal health of the woman/infant in the given situation
2. Process Support the normal process of birth
   Continued vigilance and attention to detail
3. Traits Belief in the normalcy of birth ,Clinical objectivity, Knowledge of self
   Exceptional clinical skills & Judgement, Calm, Commitment to the

health of women & family, Patience, Confidence ,Wisdom, Decisive,Intelligent,Intellectually curious, Mature, Positive outlook, Persistent, Assertive

Under the general dimension of Caring:

1.Outcome The woman and family have a health care or birth experience that is respectful & empowering

2.Process Respect the uniqueness of the woman & her family

Creates a setting that is respectful and reflects the women's needs

3.Traits Possesses integrity, Honesty, Compassion (caring, kind, empathic, sympathetic), Trustworthy, Commitment to empowerment of women Communication skills, Flexibility, Understanding and supportive Warm, Tolerant, Non-judgmental, Commitment to women/family Centered, Gentle, Humble, Approachable, Interest in others , Nurturingn Not focused on self, Realistic, A woman and/or a mother, Reassuring and soothing, Generous and loving spirit, Sense of humor, Personable and Spiritual

Under the general dimension of the Profession

1.Outcome: Enhancement of the Profession of midwifery (includes development of knowledge)

2.Process : Continually update own knowledge

3.Traits : Accountability, enjoys work of midwifery, commitment to the

profession, motivation, professional presentation

The above-identified variables will be used as references in measuring congruence between "Espoused Theory" and "Theory-in-use" of midwifery clinical educators as perceived by midwifery students during their last clinical experience/integration .

Objectives

1. To find congruence between midwifery student 's espoused theory of midwifery and that of exemplary midwives (Delphi Experts)
2. To establish the extent to which exemplary midwifery practice is observed during integration
3. Potentially find an association between the extent of implementation of exemplary midwifery practice and the location of the clinical settings
4. Potentially find an association between the type of education program and the implementation of exemplary midwifery in clinical education
5. Potentially establish a relationship between the traditional type of instruction or distance learning and the degree of implementation of exemplary midwifery process

The above objectives can be reformulated to result in the following null hypotheses, which will be described in more details in chapter III.

Null Hypothesis 1 .There will be no difference between the respondents' espoused theory and that of Delphi Experts on all 39 Dimensions. (espoused theory being expressed in the Ideal perception of exemplary midwifery Process)

Null Hypothesis 2. There will be no difference between the espoused theory of Delphi Experts and the degree of emphasis on the observation on Actual exemplary midwifery process by graduating student during last clinical experience/integration on all 39 dimensions

Null Hypothesis 3. There will be no difference between the Actual observed Exemplary Midwifery process during Integration and the Ideal espoused midwifery theory of respondents , using thematic dimension groupings.

Null Hypothesis 4. That there will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home Birth Practice, Birth Center, Level 1&2 Hospital, or level 3 Hospital .

Null Hypothesis 5. That there will be no observational difference between the respondents' observation of exemplary midwifery process and types of educational programs, i.e. Certificate, Masters, BA to BSN to CNM, or AD to BSN to CNM

Null Hypothesis 6. that there will be no difference between the observed emphasis on exemplary midwifery process by respondents from Traditional Programs, (on site) versus Distance-Learning programs (web-based or others)

Definition of Terms

Congruence : According to the Webster New Collegiate Dictionary, congruence is the quality or state of agreeing or coinciding

Espoused theory : A 'Theory", according to the Oxford is a set of ideas formulated to explain something. Argyris and Schon define theory as a vehicle for explanation,

prediction or control. Theories constructed to explain, predict, or control human behavior have special features in that they attempt to explain and justify human behavior: In situation S, if you want to achieve consequence C, do A. Espoused theory is a theory of action to which a person gives allegiance to . When asked how a person would behave under certain specific set of circumstances, it is his/her espoused theory that is formulated.

Theory-in-use: The theory that actually governs a person's actions. Theory-in-use cannot be constructed by asking an agent . It must be deduced from observation of behavior. "When you know what to do in a given situation in order to achieve an intended consequence, you know what the "theory-in-use" for that situation is "

Nurse-midwife : An individual educated in both discipline of nursing and midwifery. According to the WHO, a midwife is

" A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery" The work within the scope of midwifery is more clearly described by the ICM's definition:

She must be able to give the necessary supervision , care and advice to women during pregnancy , labour, and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. " (Rooks, 1997, p6)

Clinical experience, integration: A clinical experience, during professional education, is that part of the education when the theory previously learned ideally is put to practice. Clinical experience cannot match the theory perfectly, since human experience is "murky" and difficult to control. Student are supervised by preceptors during their clinical experience. They are at first given partial responsibility for the care of patient, and the intensity and independence is increased as the student becomes more experienced.

In midwifery, in most programs accredited by the ACNM, students first rotate through various clinical subjects, such as "Gynecology", "Antepartum", "Intrapartum" , "Neonatology" and "Postpartum". Each set of experiences extends over several weeks, at the completion of which the student is expected to have a basic , agreed-upon knowledge base, and a modicum of comfort in the clinical setting. When the rotation is completed, students finalize their clinical knowledge by integrating the various components of their clinical. Integration is the final clinical experience, lasting between 6 and 10 weeks, at the completion of which the student will be able to function as a beginning midwife. Preceptors during clinical experiences are always midwives, chosen for their knowledge and willingness to socialize the student into the profession of midwifery.

Exemplary midwifery practice : What processes, outcomes, qualities and traits are defined as the best and most valuable attributes of nurse-midwifery practice.

Distance learning: Didactic component of the curriculum presented through a medium other than on-site presence. It can be through mail, through web-based courses. In this study, only programs that rely almost exclusively on distance are being targeted.

Traditional programs: On site instruction . Usually in the form of lecture, seminars.

Level 1 and 2 hospitals : Community hospitals. Equipped to handle obstetrical and neonatal emergencies.. Do not have an anesthesiologist or an obstetrician in house at all time

Level 3 hospital : Major perinatal center, teaching institution. Equipped to handle all obstetrical and neonatal emergencies. There is always an anesthesiologist and usually several obstetrician in place. Specializes in complicated pregnancies and deliveries, but will also accommodate normal.

Birth Center: Free standing, outpatient , home like office, or building, where healthy pregnant women receive their care, deliver their babies, and spent the first few hours after the birth. They usually go home with their babies a few hours after the birth

Home birth: Low risk birth can happen in the home of the patient, supervised by a nurse-midwife. Only low risk mothers are screened to deliver in their home.

Delimitations

This study is based on the observations of midwifery students in clinical situations only. It does not single out preceptors in particular, but looks at the clinical experience as an aggregate of several preceptor-student interactions. It is limited to newly graduated midwives, all having finished their education no longer than 14 months ago, and all having been successful at passing their ACC/ACNM board exam. Unsuccessful students were not included.

It infers that exemplary midwifery practice is such as defined by the midwives surveyed in the Delphi study.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Chapter II will be divided in two sections. Section 1 will offer a review of the relevant literature. Section 2 will present a short historical background of the profession of midwifery in the United States.

Introduction

The literature review relevant to this particular study was anchored on the perception and definition of values in general, as well as literature published on educational and professional values. Research on values germane to related professions such as medicine and nursing were compared to literature on midwifery values. The teaching of values in medicine and nursing, as well as midwifery, was explored. Seminal research on theory-practice gap noted in professional education was examined. Finally, an overview of action research, as it pertains to the work of Schon and Argyris, was reviewed.

Values

The Webster New Collegiate Dictionnary (Wolfe, 1976) defines value as something "desirable, useful, important, having an ability to serve a purpose, to cause an effect, to be of great worth". The Latin origin of the word, *vale* also translates as a dynamic of " acting in a strong manner". Rokeach (1968; 1973; 1979) inquired into the meaning and sociological importance of human values and provided an important

contribution the this body of knowledge. Values were defined as goals in the dynamic pursuit of something perceived as desirable, involving both affective and behavioral components. Values were neither neutral nor static.

Rokeach (1973) also linked value and organization, defining value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5). Here Rokeach assumed a value to be enduring , if not absolutely permanent. Values can change over time, but they are usually stable enough to propel humans into a directional trajectory. Values are organized into a hierarchy of a value system, also subject internal change during a life span .

Values are also defined as beliefs, which is a somewhat unusual attribution considering that beliefs are usually held to be intellectual constructs, free of emotional overtone (Eddy, 1989). Rokeach argues that values can be classified as prescriptive or proscriptive, whether the end status they seek is perceived as desirable (prescriptive) or undesirable (proscriptive) .

Another important point in linking the concept of value to that of espoused theory versus theory-in-use, is the classification of values as instrumental (i.e. as in leading to action, such as forgiving, helpful, honest) and those concerned with personal or social ends (i.e. terminal, as in freedom, equality, a sense of accomplishment). Rokeach (1979) argued that a person's choice of environment will reflect their need to minimize value discrepancies, and that a person's individual needs will be cognitively represented as values.

Williams (1979) reflected that all human organizations develop normative orientations in order to support their social cohesiveness. The most important normative elements are norms, defined as specific obligatory demands, rules, and *values* which is the criteria of desirability. Institutions, being the primitive association of human groups, are not the generators of values, but are actually conceived as the network of complex set of rules, giving rise to the notion that values created institutions as opposed to institutions creating a set of rules/values.

Individual differences are seen in the hierarchy they give a set of common values rather than in the actual presence or absence of certain values. Value patterning differs not only in hierarchical ordering, but also in other important points, such as extensiveness of adherence, universality of application, and consistency. The relationship among sets of values will also change depending on the fluidity of ambiguous social situations, which are typically the setting for human behavior. Values always follow the contour of the physical world. They are adaptable, they can be learned, and they can be changed.

Sloan (1980) connected value to a goal that is imprinted early in life and psychologically benchmarked as a constellation of related behavior(s). Individuals value a certain object or behavior which then gives them a very strong impetus to reach a goal. Sloan linked value to direction and action .

Scheibe (1970) distinguished between beliefs and values:"Values refer to what is wanted, what is best, what is desirable or preferable, what ought to be done. They suggest the operation of wishes, desires, goals, passion, valences or morals. (p.42) . Beliefs can be labeled true or false, and they can be submitted to standards of veridicality.

Those very standards that people will use to judge the belief, however, are not so easy to grasp and define.

According to Scheibe, values are a product of the interaction between the person and the situation at hand. Scheibe reviewed work done in cognitive psychology and extracted some partial conclusions, subject to further investigation. Role modeling (for example, child-parent interaction) was identified as a situation where behaviors and values are adopted by imitation and identification.

Walhout (1978) attached the concept of un-reachability to the hierarchy of values. People, through self-evaluation, catalogue their needs and then infuse with value that which enables them to try to meet them. There is a dynamic quality to values ,however un-reachable, as they are adopted to meet the challenges of life's experiences and necessities.

Professional values

A trade is a skill often acquired through extensive practice, preceptorship and mentoring. Since the Middle Ages, licensure and guilds, offered tradesmen a means of protecting their skilled knowledge from being claimed by non-tradesmen.

Trades are different from professions. Professions are other-oriented. Both possess a unique body of knowledge, which can be acquired through extensive training and mentorship. Both imbue their body of knowledge with an element of secrecy. Professional knowledge is protected from public acquisition by difficult admission to schools and practice centers. Coe (1970) states that a profession is characterized by a body of knowledge, a service orientation, a collegial organization, licensure, and a special mandate. Additional attributes and traits contribute to the final profile, such as, self

policing and regulating, determine its own standards, ,and gaining increased rewards from having professional status.

Larson (1977) examined the rise of professionalism and noted that the status of professional is undeniably a middle class attribute and a "typical aspiration of the socially mobile children of [the] industrial [period]". The author also notes that professions with high status ranking tended to rank high in marketable skills. Larson suggested that through professionalization, the group of individuals identifying themselves with the profession, are able to control the marketing of their special skills. By obtaining the additional power to self-evaluate and self-regulate, they can almost become immune to external regulations.

Freidson (1970, 1975,1989), in his book, The Profession of Medicine, conducted seminal work on the medical profession and the sociology of medicine. The author stated that physicians are the most prominent members of the generally recognized professions. The profession of medicine is self regulated to the highest extent. Physicians have officially adopted, at least in the public eye, a strict moral standard, which imbues the profession of medicine with total credence in society as well as the general population. The source of medicine's professional status, is attained and maintained by the " protection and patronage of some elite segment of society, which has been persuaded that there is some special value in its work" (p. 72). If the work of a profession eventually diverges from what is expected of it from society, it may then have trouble surviving.

Paramedical professions, nursing as the prototype, lack autonomy. For example, they do not have reciprocity in taking/giving orders to physicians. According to Freidson,

nursing cannot consider itself a profession when it is organized around a powerful profession and lack basic autonomy.

Hunt and Symonds (1995) studied midwifery as a social service. The authors identified midwifery in the hospital institution as occupying the classic terrain of the semi-professional. There is a concrete sphere where the midwife may practice, and this sphere has been created by a more powerful profession [medicine]. The authors state, "the power and autonomy of midwives working on the labour ward is fenced around by constraints which have been imposed historically and which are an everyday experience" (p. 21).

This encapsulated overview of the sociology of the professions helps to create a picture of the medical profession in America, together with an understanding of the position of two related health professionals, nurses and midwives. In the current health care environment, the profession of medicine ranks at the highest rung of the professional groups. Related non-medical health professionals, while ranked lower on the societal scale for professional recognition, are engaged in creating a unique and equivalent position. This researcher only examines the professional groups of nurses and midwives, as integrated in the professional group of nurse-midwives. The purpose of the study is to narrow the investigation further to the concept of "value" as one component as an identity as a profession.

Professional Values in Nursing

Research about professional nursing values is extremely limited or non-existent. The professional body representing nurses, American Nurses Association, has identified through consensus, a code of ethics which implicitly describe a set of values. An

examination of implicit or explicit values have not been extracted by nurses themselves. Studies identifying and comparing values among different nursing professional groups or among different academic preparations are only beginning to emerge.

When comparing the values held by nursing faculty and nursing students using the set of values issued by the American Association of Colleges of Nursing (AACN) (Altruism, Equality, Esthetics, Freedom, Human Dignity Justice and Truth) , nursing faculty ranked the values of human dignity higher than aesthetics as compared to generic students who ranked aesthetics higher than human dignity (Thurston, Flood, Shupe,& Gerald, 1989).

Eddy, Elfrink, Weis, and Shank (1994) identified seven essential values using their Professional Nursing Behavior Instrument. These essential nursing value are altruism, equality, esthetics , freedom, human dignity, justice and truth. The authors noted that faculty ranked some values significantly higher than students. Equality, freedom and human dignity were ranked higher by faculty compared to the student rankings. Students ranked aesthetics and altruism higher than faculty rankings.

Comparing the values held by nursing educators in the United States and England, Schank and Weis (2000), using the Nursing Code of Ethics, found no significant difference between the two groups. In 1989 Schank and Wise used the Nursing Code of Ethics to examine the differences in values between nursing students from a baccalaureate degree program and graduates nurses from a secular and nonsecular programs. They found no significant difference between the groups. Values most frequently identified were related to patient care rather than to social issues of the profession.

In the review of available literature, nursing values, especially those concerned with patient care, equality and human dignity are congruent when compared between nurses from different programs of between the United States and England. Nursing Students attached more importance than their faculty to issues related to esthetics.

Professional Values in Midwifery

Over the last few decades, researchers have attempted to examine the "true essence" of midwifery. These efforts have included: (a) delineating the scope of practice of nurse-midwives; and (b) defining the practice of midwifery by direct observations of practice, by interviews with practitioners, by analysis of midwifery processes and outcomes; and by interviewing recipients of midwifery care.

Thompson, Oakley, Burke, Jay, and Conklin (1989) used the philosophy of the midwifery profession, defined each component term/concept, and added indicators for each term/concept by observing midwifery practitioners at work. Clinical practice was videotaped and a panel of interdisciplinary experts observed the audiotapes. Concepts of interaction between midwife and client were classified using discussion and consensus. The concepts/indicators were then validated through review by program directors and practicing midwives. Detailed indicators (over 100) were grouped under the components (24) of the six concepts of the philosophy of nurse-midwifery: safety, client satisfaction, respect for human dignity and client self-determination, respecting for cultural and ethnic diversity, family centered care, and health promoting care.

Kathryn (1996), used grounded theory in her search for true midwifery knowledge, searching for a theoretical model of midwifery knowing in expert clinical

practice. The author interviewed 17 nurse-midwives (American and British) who practiced between 1925 and 1965 at Frontier Nursing Service (FNS) , a pioneer nurse-midwifery outpost set in the Appalachian mountains of Eastern Kentucky. This community-based comprehensive model of community and family care began in 1925 and remains active today as a community service as well as an educational program. The author described a grounded theory of "Profound Knowledge" where environmental, community, family and women "Knowing" components/qualities of knowing contributed to the clarification and delineation of a unique epistemology of a midwifery body of knowledge. Qualities in each of the four components of ways of knowing were identified as critical to clinical practice and theorized as critical to sound clinical outcomes.

Lehrman (1988) identified seven key concepts: prenatal care satisfaction, labor support (linking human presence in labor to successful outcome), personable environment, positive presence transcendence, labor satisfaction and enhanced self-concept. Lehrman's three-dimensional model of care integrated the process of midwifery care and with improved clinical outcomes.

Rooks (1999 b) described the midwifery model of care and how it differed from the medical model. Her dialectic was based on observations of clinical experiences and midwifery/client relationships and on a comprehensive review of related midwifery literature. Rooks posited that midwifery and obstetrics were complementary but different philosophies with overlapping but distinct purposes. While both shared a desire for positive outcomes, i.e. a healthy mother and a healthy baby, there was a remarkable difference in each profession's definition of the concept of health care The medical

model diverged from the midwifery model in that medicine follows a more authoritarian, paternalistic approach, while midwifery establishes the pregnant woman as a partner in decision-making. The midwife sees her role as guide and educator, which is more in harmony with a feminist philosophy.

Teaching Professional values

The transmission of professional values in educational programs has been explored by the academic health professions, but only recently within the clinical/service and clinical education sector. Based on definitions of value(s) and the dynamics of value systems, the transmission of values to the next generation of professionals is considered an important aspect of the curriculum. Curricula are used as a means of defining new values and validating older ones through courses on professionalism. Hansel and Dickey (1998) argued that it was more important than ever to include seminars on true professionalism in medical school to help students balance financial and professional considerations. Managed care and cost containment are in conflict with professional standards and are perceived by many in the profession of medicine as a threat to the practice of medicine as a profession. The authors argue that it is imperative to "Pass the Torch" and keep professionalism and values alive through seminars on true professionalism.

Instead of leaving professional development to chance, Wear and Castellani (2000) proposed to engage students in well-defined and structured content seminars on professionalism in medicine.

Teaching Professional Values in Medicine

Medical education has taken a serious look at the clinical curriculum and the modeling of medical values as expressed in the Hippocratic Oath. Recent studies found the modeling of moral values by clinical instructors, as perceived by students, was often misrepresented. Maheux, Beaudoin, Berkson, Cote, Des Marchais, and Jean (2000) noted that students indicated that the behaviors were absent from their observations of preceptor clinical practices. The study suggests the existence of a substantial gap between what students are expected to learn and what they are actually learning .Only 46% of medical trainees agreed that their teachers displayed characteristics such as sensitivity toward patients.

Medical students' perception of their teachers as humanistic physicians

Statement	Student Groups	Agree/ Disagree
On the whole, would you agree or disagree that most of your teachers:	2nd –year students	78% (22
Value human contact with their patients as an important component of patient care	Senior clerk P value**	68% (32) 0.003
Are concerned about the overall wellbeing of patients , not just their presenting complaints	2nd – year student Senior clerks P value	65% (35) 57% (32) 0.04
Are concerned about how patients adapt psychologically to their illness	2nd – year students senior clerks p value	54% (46) 29% (71) < 0.001
Spend time educating patients about health problems	2nd – year students senior clerks p value	68% (32) 57% (43) 0.006

Are good role models in teaching the patient-doctor relationship	2nd – year students	74% (74)
	senior clerks	58% (42)
	p value	<0.001

** For differences between groups

Table from, Maheux,B., Beaudoin C., Berkson L., Cote, L., Des Marchais J., & Jean P. (2000). "Faculty as humanistic physicians and teachers: the perceptions of students at innovative and traditional medical schools" Medical Education, 34, 630-634.

Futhermore, Stern (1998) observed the interaction between faculty and students and reported that the values stated in the Hippocratic Oath, which represent the "ideal physician' were taught sporadically in the clinical curriculum.

Table: Curriculum Comparison

	Recommended			
		Local		
Value Taught	Global	Students	Residents	
Honesty	++	++	+	+
Acountability	++	++	++	++
Compassion	++	+	++	++
Service	+	-	++	++
Industry	-	-	+	++
Interprofessional	+	+	++	++
Public Health	++	+	+	-
Self-Policing	++	++	+	-

++ strongly present in these documents
+ minimally present in these documents
- mostly absent

Table from, Stern D. (1998) Practicing what we preach? An analysis of the Curriculum of Values in Medical Education .The American Journal of Medicine, 104(4), 569-575.

Teaching Professional Values in Nursing

Studies in nursing suggest that there is a tenacious covert curriculum, expressed chiefly in the clinical settings, which inhibits the growth of new graduates toward a more holistic, individualized , patient-oriented philosophy of nursing care. King and Gerwig, expressed the problem in these terms: "Nurses even a year after graduation, are still unable to apply their knowledge and are unable to make appropriate changes in the system to make it more patient-centered" as cited in Pitts (1985) noted further, " [the above description] suggests that graduates display an acceptance of thoughtless and technical routines of care that are passed from nurse to nurse rather than the intellectual and creative endeavors that most curricula are designed to emphasize."

Eddy (1989) questioned whether students actually acquire the values espoused by their profession by the end of their formal education. The author sought to answer the significant question of whether there were any differences in the professional values of baccalaureates nurse educators compared to senior nursing students. Using the Professional Behavior (PBN) instrument the researchers reported observing an incongruency between the two groups.

Significant Value Differences Between Faculty and Senior Students

Value	Group Valuing More Highly	t Value	p Value
Equality	Faculty	3.46	.002
Esthetics	Students	-3.47	.002
Freedom	Faculty	5.14	.000
Human Dignity	Faculty	2.58	.016
Total Value Score	Faculty	2.11	.045

The study demonstrated that faculty valued equality, freedom, and human dignity more highly than the students. Students, as noted in previous studies, valued aesthetics more highly than faculty.

Teaching Professional Values in Midwifery

There is limited research related to the teaching of professional values in midwifery. Given the difficulty in achieving a consensus on the international definition and scope of practice of the midwife, and given the relative small size of the professional body, research in midwifery has been focused on clinical or political issues.

In the wake of their nursing/midwifery/home health nursing curricular reform of the last decade, researchers in England have studied aspects of preparation of midwives towards autonomous practice, using the grounded theory approach. Autonomous practice being essential to the professional status, student midwives are educated to use their initiative and be questioning, when in fact, "within the hierarchical structure of a busy ward, students were expected to obey orders and it was easier to conform than to challenge" (Currie, 1999 ,p. 289) Even if making complex decisions is considered an essential component of autonomous practice, there was little evidence of its presence in clinical decision making. The author recommended that strategies be developed and implemented to enhance student decision making and clinical judgement. It is assumed that such a curricular change would enhance self-esteem and move the profession towards autonomy. Historically, English midwives have differed from their American

counterpart by their acceptance of the medical model of care. A recent reform, "Reform 2000" has focused on autonomous practice and a new focus on the normal process of birth in clinical practice, also a hallmark of American midwifery exemplary practice.

Marchese (1993) investigated the factors influencing decision making in preceptors' evaluation of midwifery students' clinical skills. Among program directors surveyed, those who responded admitted to the inclusion of emotional aspects without being specific as to whether or not these reflected professional values. Respondents did identify that evaluation of skills leading to safe performance was a priority in clinical practice.

Scheideberg (1999) reported that service-learning entwines community work/volunteerism with academic instruction, allowing the student to delve deeper into the lives of the women and families. The service-learning model directs the student to fully embrace the midwifery philosophy espoused by the ACNM. Several benefits were derived from educating students in this fashion: (1) the teaching and learning were both more immediate and effective; (2) there were long term relationships built between students and the community; and (3) there was on-going communication between the campus and the community. The author strongly supported the service-learning model of teaching and learning. Students evaluated their experiences as positive and reported benefiting from the service-learning model.

Other studies published during the last five years identified methods of instruction (Johnson & Fullerton 1998) or Ideal values for 33 curriculum topic (Bellack, Graber, O'Neil,& Musham, 1998) scaled by Program directors as to their desirability vs implementation . These studies did not include clinical education.

Professional Education and Theory-Practice Gap

In the early 1980's, researchers flagged interesting slants in nursing education, pointing to a theory-practice gap, or for better words, a hidden curriculum that asked to be illuminated (Alexander, 1983) . Armitage and Bunard (1991) attempted to search for new roles in clinical nursing education that would help close the gap between theory and practice. The role of mentor, as a wise, reliable counselor who guides the neophyte nurse has been proposed as an effective instrument in closing the theory-practice gap. The authors argue that, by it's very nature, it is counter to adult learning theory. Adult learning theory stipulates that adults learn best when independence is fostered. Preceptors, however, are more concerned in enhancing clinical competence, which allows for effective, thorough role-modeling. Preceptors, through role-modeling, are effective at narrowing the theory-practice gap.

Using Action Research, McCaugherty (date) investigated the concept of theory-practice gap. The author identified theory as being knowledge by description while practice was knowledge by acquaintance. Learning by acquaintance could be enhanced though post-clinical conferences, log/journal keeping, and study days. The author concluded that the theory-practice gap was a multi-factorial problem that could be minimized, if not solved, through curriculum adjustment and practicum/clinical support.

Theory-practice gap is often expressed as the teaching of a set of values that seem to part or differ from the chosen norm of a profession. This teaching is referred to as the "covert curriculum" or the "Hidden Curriculum". Bevis, Murray and Watson (1989) identified three types of nursing curriculum, the "legitimate", the "illegitimate",

and the " hidden". The legitimate teaches what is implicitly or explicitly agreed upon by the faculty. The illegitimate is the one kept in the closet. It values and teaches caring, compassion, power, ethics, politics, being accountable and responsible. This is the curriculum that cannot be graded, hence its official nonexistence. The hidden curriculum is transferred by the way a teacher teaches, the way the teacher interacts with students. The teacher is often unaware of what is being transmitted to the student through the teaching actions and interactions with the student(s). The hidden curriculum colors and shapes the student's subtle socialization into nursing.

Being concerned about what nursing is "really" teaching, Pitts (1985) observed that the overt curriculum was composed of core skills and information necessary for entry into practice. This type of knowledge was usually transmitted in a traditional way, face to face, or through distance learning instruction, and included a well-structured summative evaluation. The socialization of students into the profession was covert, and often hidden from scrutiny or evaluation. This covert curriculum was subject to a multitude of influences and interactions that served in keeping nursing in its subservient status. "The professional indulges in self-effacement and provides services, not on the basis of client need, but on the demand of other more powerful professions and hierarchies." (p. 36). Pitts further noted that much of the objective façade of education concealed the political interests of sections of society. Pitts concluded with an observation from Habermas, that critical understanding can help close the gap between facts and humaneness and can contribute to a real understanding of professional values. Only then, Pitts argued, will nursing be able to demonstrate agency and make positive changes in the health environment.

Medical education is also objectively examining the teaching of professional medical values. Stern (1998) used participant observation to clarify the notion that medical students learn a parallel curriculum alongside the well-known knowledge and skills. He argued that one hypothesis explaining why medical students were not adopting "ideal" values was that they were learning a different curriculum alongside the official one. This "other" curriculum was teaching them a different set of values. After observing medical students in clinical setting for 6 months, the author noted that most of the value teaching occurred in the evening, in the absence of attending physicians. Medical students were receving most of their value teaching from the residents during the evening clinical hours.

Hafferty and Franks (1994) answered the demand from lay and medical audiences to intensify the teaching of medical ethics. The authors explored the relationship between the formal and hidden curriculum responsible for the teaching of medical ethics to medical students. They looked at the ethics content in the curriculum – both formal and informal – to determine why or if ethics content was marginalized? The authors argued that even if a well-designed ethics curriculum were implemented, it would fail to meet its goals if there was no congruence with the hidden curriculum, as observed by the students through the ethical behaviors of their role-models. The authors were cautious about painting too bleak a picture, they highlighted the importance of becoming aware that ethical and medical training in general does not occur in a cultural vacuum. The ethic taught in the hidden curriculum is often in direct conflict with what is being presented in formal courses on medical ethics. The consequence of this incongruence is to marginalize the place of medical ethics in the curriculum and to support the belief that

ethics is subjective and resides in one's personality alone. The authors recommended that (1) those who teach medical students need to become more aware of the many beliefs surrounding the neophyte; (2) that it is better to assess the presence and content of a hidden curriculum using trained outsiders, and not just through faculty-student observations/responses; (3) that faculty must be able to identify the ethical issues they encounter, and (4) that students need to be given real life opportunities to appreciate the relevancy of ethics.

Ho (1989) examined the hidden curriculum in midwifery education and observed inconsistencies that resulted in attitudes of idealism and humanitarianism changing to attitudes of cynicism and Machiavellism as the students' clinical competence increased Such changes in attitude were identified as detrimental to the profession. The essence of the hidden curriculum was to pass on the status quo, creating a barrier to change. Ho brought the problem to the profession's attention but did not recommend solutions.

As we have seen in this overview of the hidden curriculum, the hidden curriculum is pervasive and powerful in professional education. Awareness of the problem and efforts to uncover the content of such a curriculum is the solution offered by most experts at this point.

The Place of Birth

Nurse-midwives practice in a variety of locations, some in outpatient clinics only, some as faculty in Academic settings. Most attend births in well defined places: community hospitals, perinatal centers, birth centers or in the client's home.

The American Hospital Association (AHA) maintains strict criteria in the definition of community hospital versus perinatal center. These criteria specify differences in terms of type of services offered and the density and specialty of the personnel involved. For example, when defining criteria for intrapartal care (the time during labor and delivery) AHA clearly delineates the level of acuity and complications assigned to each type of hospital. A perinatal center will be equipped to deal with emergent situations with personnel on-site 24 hours/day. The perinatal center will be able to care for a premature infant (less than 2,500 grams) and also for a very premature infant (less than 1000 grams) as well as any situation that is unexpected and occurs in the newborn period. This care often requires the use of specialized and expensive technology not found in community hospitals.

Perinatal centers are often teaching centers for physicians, nurses, and other allied health personnel. By necessity, there is close supervision by senior and experienced health care professionals in perinatal centers. Pregnant women suffering from superimposed medical illnesses find the medical expertise they need in perinatal centers.

Community hospitals often rely on experienced and well-trained nurses to manage most of their laboring patients. Competent midwifery/obstetrical screening during the prenatal visits and during the perinatal period has weeded out most obvious complications. Only minor deviations from normal are expected. The newborn is not expected to need more than routine care. This is still a hospital, however, and thus the domain of medicine and illnesses.

Hunt and Symonds (1995) argue that the development of organizational structures, like hospitals, is thought to have been the result of a need for surveillance of a large population . The open design of these structures is usually such that many people can be observed efficiently by a few. In a hospital, the design of wards, or rooms, are most often located *around* a nursing station, with glass fronts, making privacy impossible. Supervision was and remains the modus operandi for hospital architecture. The person with the greatest authority is invisible at first (Physician), yet their presence permeates the space. Workers of lesser social standing, remain visible. This sociological study was conducted in England, where nurse- midwives are the primary care givers and managers of birth on the labor floor.

In the history of medicine, hospitals were facilities where the homeless and the very poor were gathered to receive medical/nursing care, away from the dangerous streets. The affluent, or those who could afford private care, received medical and nursing care in their private homes. Birthing was rarely conducted in hospitals. Management of pregnancy and birth was the domain of midwives and later midwife-doctors. Birth, even with complications, was done in the home of the mother, predominantly by midwives. Barber surgeons were called to difficult births to perform primitive cesarean sections, often to save the child, with the mother expected to die. With the growth of medical knowledge and the need to teach students of medicine, hospital became, increasingly, places for the practice of medical clinical education. Once again, the largest number of patients came from the lower classes, the poor, and the homeless. Large teaching wards provided medical students with the opportunity to see and practice their trade, caring for disease at first, later obstetrical wards were added as well. Midwifery and birth remained

distinct from medical interest late into the 18th century. Attendance at birth by men was considered immoral. Midwives, male-midwives, surgeons, and barber surgeons lacked any recognition as a profession by the rising professional body of physicians. It was not until the middle of the 18th century that midwives began to feel the effect of "competition" from medical men. Societal pressures against midwives included negative descriptions of midwifery care by physicians, attributing poor outcomes to un-educated midwives; lack of educational opportunities for women in general; lack of access to new scientific knowledge related to the growing field of obstetrics; the acceptance of surgery as a recognized specialty of medicine; the replacement of barber-surgeons on difficult cases by obstetricians; the growing specialty of obstetrics and gynecology; the establishment of teaching programs for male-midwifery/obstetrical care in teaching hospitals; and the growing acceptance by women of the "scientific" model of obstetrical care. In 1701, Hendrik van Deventer, presented the Novum Lumen, a series of plates depicting the first accurate description of the pelvis and deformities, entitling him to the name, Father of Modern Midwifery. By the end of the 1700's, the Lying In Movement, had transformed the practice of birth in the home to the practice of obstetrics in hospitals.

This doctor/pathology oriented atmosphere found in hospitals created a malaise over the second half of the twentieth century when women tried to reclaim their participation in birth, paving the way for the "Home Birth" movement. Numerous feminist authors (Rothman 1983; Wertz & Wertz , 1977) described how, frustrated by an over-paternalistic des-empowering attitude of the medical profession vis a vis the event of childbirth, women chose to have their babies at home. Rothman shares her experience of the early seventies, when , as a well educated women capable of understanding the

physiology of the birth process, she was treated as a reckless seeker of new adventures in seeking medical coverage for her planned home birth. Gaskin (1992) in birth stories told from The Farm, a commune set up in the late sixties in Tennessee, tells of poignant experiences of birthing families and of compassionate, albeit few, willing helpful medical practitioners.

At the present time, nurse-midwives may chose to develop a home birth practice, but for reasons of scheduling, difficulty of third party reimbursement, and an often hostile/non-supportive medical environment, few chose to do so . Only 1% of nurse-midwives deliver babies in the home. (American College of Nurse Midwives,2000) . Midwives who chose to practice in this location have a well delineated protocol, work with a well trusted back up obstetrician, and usually feel capable to apply their knowledge freely, without the imposition of hospital protocol and restriction.

Another area of practice for nurse-midwives is the Free-Standing Birth Center. Viewed by some authors as a compromise between the freedom of home birth and the restrictive environment of the hospital , the Birth Center offers the option of natural childbirth (Rothman, 1983). However, Rothman argued that while Birth Centers offer more freedom than the hospital, they still are not home. They require travel to the birth center while in early or difficult labor and often traveling back home within hours after the birth. In addition, birth centers are restricted by a rather inflexible risk management process. They do meet the need of nurse-midwives and a growing number of families interested in birth outside the hospital. Birth centers have a long history of safety and reported high satisfaction from the women who used them. They are an

important out-of-hospital option for birthing women and their families (Turkell, 1995; Zabreck Simon & Benrubi, 1983).

Nurse-midwives have a variety of options as an expression of their philosophy and practice preferences/choices. Home birth practices offer the most autonomy, the hospital possibly the least, with the Birth Center a often adopted compromise. If the philosophy, as described by the American College of Nurse-Midwives, and described in the literature, includes values of safety, family-centered care, respect for the woman and her family in it's diversity, client satisfaction, respect for human dignity and self-determination, and the promotion of health and normalcy for birthing mothers, can exemplary midwifery be practiced in the confine of a hospital?

> "Real" midwifery is not determined by the locale or by medical and obstetrical normalcy. "Real" midwifery is not determined by whether the woman is not in stirrups, has no limits on her visitors, does not get moved to a delivery room, or can eat and drink during labor. "Real" midwifery is what we do wherever the woman is . (Varney-Burst, 1990)

Action Research

The Theory of Action was born of a need to create a dynamic understructure spanning the global knowledge of the social sciences in the mid-century. The point of reference for action research is the action of the individual, collective, or organisms, referring to acting units (Shils, 1951). The major concern of action research is to determine if the nature, purpose and orientation of action evolves from the individual(s) or from the(ir) organization. The theory of action is also the identification of those dynamic values that propulse individuals toward a determined action. In that they are the

reason for most actions, values are the units of research. Values, in as much as they can be isolated, are studied and identified by action researchers.

Historically ,Kurt Lewin was instrumental in creating an interest in the Theory of Action, and later on, in Action research. Lewin developed a special language of psychology in order to study the determinants of human behaviors. He used simple, everyday words to describe his concepts. Terms such as "life space" and "vectors" were used to explain motivation and value orientation (in Scheibe, 1970, p. 14-15). Lewin considered the true test of his theory to be their applicability to real life situations. He led psychological research out of the laboratory into real life situations. Lewin recognized that most of decisions made by human beings are made to answer a social need and/or reality.

Argyris, Puttnam and Smith (1985) defined action science as "an inquiry into how human beings design and implement action in relation to one another" (p. 4). The key feature of action science is the knowledge that human beings can implement action in context, and that the action is discomfirmable. Several themes from Kurt Lewin are applicable to Action Science.

1. Action science involves experiments on changing behaviors on real problems, planning, acting, and evaluating. Intended change involves re-education at the levels of norms and values. Effectiveness depends on participation of client.

2. Action science changes the status quo from using a perspective of democratic values : observation of actions are confirmed and validated by the participants in the action

3. Action research is intended to contribute simultaneously to basic knowledge in social science and to social action in everyday life.

4. Action science is inquiry in practice. It is a knowledge that will serve action. Reflection on the action may lead to uncovering some tacit knowledge embedded in the action .

The theory of action approach begins with "the conception of human beings as designers of actions " (p. 80). Human beings devise theories in order to make sense of their actions. There are two kinds of theory of actions, espoused theory and theory-in-use. Espoused theories are those actions or held beliefs/values that an individual claims to follow, and theory-in-use, are those theories/beliefs/values that can be inferred from their actions. Theories-in-use are often tacit "cognitive maps" used to design action. They can be made explicit by well guided reflection on action . According to the authors, becoming a scientist is learning to reflect on reflection-on-action. Becoming an action researcher and scientist involves observing real life situation, reflecting on the action, creating new patterns of action and validating those new patterns with the actors, thereby creating congruence between the espoused theory and their theory-in-use.

Section 1 of Chapter II reviewed the relevant research published on values in general, including the definition given by experts, and the literature on professional values as defined by the sociology of the professions. Comparisons of professional values espoused by nursing, midwifery and medicine were reviewed. The diverse settings of nurse-midwifery practiced were presented and applicability of espoused values in different settings was briefly introduced. The concern expressed by educators related to the effective and appropriate methods to teach professional values in nursing,

midwifery and medicine was highlighted. Finally, an overview of the literature published on theory-practice gap, and its corollary, the hidden curriculum, was presented. Section 2 of Chapter II will present an overview for the background of this study, a brief history of the profession of midwifery in the United States and a description of current midwifery educational programs.

Historical Perspective

The origins of midwifery are buried in history. Midwifery as a service to women at birth has always been directly related to communities and societies. Just as the village healer established their position within the tribe by exercising their power and protecting and honing their skills, so did the village midwife. The origin of the word, "mit wibe", an old Germanic root, referred to the act of being present "with women" during their lying-in period. Until the eighteenth century, when medical men began to assume the responsibility for assisting at birth, midwifery was the exclusive domain of women. (3) In most cultures, men, either priests, shaman, and later barbers and doctors were called only to assist with complications. (4) With the development of the forceps, and later anesthesia, wealthy women opted to summon the services of the obstetrician to help them in childbirth. Slowly, what had been at first an occasional referral for help " in extremis" became the norm and midwifery, being a women's occupation fell in desuetude. As technology developed, medicine opted to routinize its use and forever transformed the experience of childbirth.

Early in this century, however, the United States was faced with the dilemma of having a large contingent of foreign born midwives serving the newly immigrated

population. The high infant mortality rate discovered at the turn of the century prompted the establishment of the Children's Bureau in 1912. The Bureau was created to collect data on maternal and infant mortality and morbidity. The report was humbling, infant mortality in this country was higher than in Europe. The Flexner Report, published in 1910, illuminated the poor quality of American medical education, and worst of all, the dismal outcome of obstetrics care. Since uneducated, non-English speaking midwives attended about half of these births, it was easy to blame the poor outcome on the ignorance and unhygienic practices of emigrant midwives.

In some remote areas in America, inaccessible to medical care, the government developed training programs to educate traditional midwives and birth attendants. The results were encouraging. There were various attempts at formal education of nurses in the more specialized field of obstetrics, Maternity Center in NYC and Frontier Nursing Service in rural Kentucky. Even though the results of these endeavors were very encouraging, resulting in a high reduction in infant/maternal mortality, it remained a marginal accomplishment. The trend in this country was moving rapidly towards medicalized childbirth for those who could afford the care. Poor women were receiving, either no care and being delivered secretly at home with a midwife from their cultural background, or were being delivered in public hospitals, where free care was unknowingly traded for the use of their body in medical teaching.

Only a few Nurse-Midwifery schools were established between the 1920's and the 1960's. Nurse-Midwifery was viewed as a sub-specialty of nursing and the practice of nurse-midwifery was dominated and regulated by medicine and usually restricted to the care of the poor.

America entered the 1960's with a new energy. Women were graduating from universities in greater numbers. The wish to control their lives and their bodies led women to take a critical look at the way obstetrics had medicalized childbirth. Childbirth education, "Natural childbirth", "home birth" led to the development of a "new", or maybe resurrected, class of professionals, "lay midwives". Lay midwives described their desire to assist/attend healthy birth as a "calling" and created an informal model of education through apprenticeships with sympathetic physicians and self-help groups. They managed to carve out a small but faithful niche in the childbirth movement. Most of them practiced illegally, since they did not meet criteria for licensing in the states that offered licensing to nurse-midwives. Their educational background and experience was variable, difficult to standardize, from excellent to very poor. They offered home births, and were practicing outside the medical establishment.

The next thirty years saw the continued development of nurse-midwifery education and an expansion of the services to women who wanted a less interventive birth. Nurse-midwives were able to attend birth in the home or in the hospital. For the women searching for participation in their birth choices and experiences, hospital nurse-midwives often acted as providers and advocates against unnecessary interventions. From a few nurse-midwifery programs in the 1960's, the number increased to 48 in 1998. From a few hundred nurse-midwives practicing in the early sixties, ACNM now reports over 8,000 actively practicing Certified Nurse-Midwives and Certified Midwives. According to surveys conducted by the ACNM, nurse-midwives are working in a wide variety of locations. Some do homebirths, some offer their services as independent practitioners in hospital, most work in city clinics and hospitals within an inter-

disciplinary health care team. All of them are licensed to practice by their state of residence. All of them are nurses who have completed further education from a program accredited by the ACNM. In recent years the ACNM Accrediting body has also accredited non-nurse-midwifery programs, whose graduates are certified as Certified Midwives. Because of the recent entry of the Certified Midwife, this study focuses on Certified Nurse-Midwives.

CHAPTER III

METHODOLOGY

Introduction

This chapter focuses on the design of the study, the population of interest the development of the questionnaire and the procedures needed to implement the study. Drawing from the research question, statement of the problem and relevant literature review, variables will be identified and hypotheses introduced. Tests, statistical and others used to analyze the data will also be presented.

Design of the Study

The research design used in this study is ex-post facto . According to Newman and Newman (1977)

> Ex post facto research is generally a term that describe research which is initiated after the independent variable (the variable of interest) has already occurred. (Newman & Newman p. 177)

In this empirical study the independent variables: Types of Nurse-Midwifery Program attended; Traditional vs Distance Learning model; and Setting of Clinical experience all occurred prior to data collection. The researcher wished to determine the extent of expression and perception of selected exemplary midwifery dimensions and to identify the Independent variables responsible for any of the variance, in the actual observation of those dimensions .

Sample

The population of interest was all newly certified nurse-midwives (CNMs) of the American College of Nurse-Midwives Certification Council (ACNM/ACC) for the year 2001. These graduates were identified as the group of CNMs who would be closest to the experience of the educational paradigm of espoused theory for exemplary midwifery and the clinical experience of directly observing theory -in- action by their clinical preceptors/educators.

The research abstract, proposal outline, and study questionnaire were reviewed by the chairperson and committee of the Division of Research of the ACNM and permission was granted to obtain the mailing list of all nurse-midwifery graduates in 2001. There were 413 names on the mailing list organized by regions. The ACNM web site listed 426 successful candidates from the various programs, 13 new CNMs were lost to follow up. Of the 413 on the mailing list, three had foreign addresses. Since it was not possible to include a stamped self addressed envelope for the return of their questionnaire, their names were not used. The final sample size reflected 410 nurse-midwifery graduates for the year 2001, clustered by six ACNM Regions in the following manner:

Table 3.1

Sample of Candidates per ACNM Region

Region	N	Region	N
Region I:	38	Region IV	83
Region II	79	Region V	77
Region III	68	Region VI	65
Total			410

Nurse-Midwifery students were chosen for participation in this survey because of their assumed allegiance to the midwifery espoused model. During the interview process prospective students are often singled out because of their exploration and/or experiences with the midwifery model of care, their perceived ability to be successful candidates, their academic strengths and/or potential for success, and their interest and commitment to the midwifery profession.

Nurse-Midwifery being a relatively small professional body, with less than 500 new graduates every year, it was reasonable to assume that anonymity would be difficult to guaranty. The rationale for surveying post certification graduates was to minimize fear of reprisal through perceived lack of confidentiality , thus potentially limiting the candor of answers and/or the number of returns. In addition, participation in the survey post-examination would reassure the participants that success at the ACNM board exam would not be influenced by their responses on the questionnaire.

The rationale for choosing graduates of less than 14 months was to maximize the true recall, which gradually distorts after 14 months.(Thompson, Skowronski , Larsen, & Betz, 1996). Autobiographical recall is a complex manifestation and expression of cognitive and emotional events. According to Thompson, Skowronski,Larsen & Betz (1996) , there was a sharper decline in recall after 24 months, with events becoming blurred . In this study the respondents were cued as to past events in their last clinical/integration experience which increased the accuracy of their recall.

Identification of Independent Variables

The goal of this ex-post facto study was to determine to what degree were exemplary midwifery processes observed by graduating students during the final months of their clinical/integration experiences. The following list of variables were developed and operationally defined based on a comprehensive review of relevant literature:

Variable 1: Type of Nurse-Midwifery Educational Program Attended

Four nurse-midwifery educational models are accredited by the ACNM Accreditation Council: (1) Certificate programs for post BSN (Bachelor of Science in Nursing) applicants; (2) Masters granting programs (MS or MSN) Masters of Science or Master of Science in Nursing with Nurse-Midwifery Specialty preparation which require the applicants to have a valid nursing license and an undergraduate degree from an accredited Nursing School; (3) the Associate Degree Nurse (ADN), to BS/BSN to MS/MSN with Nurse-Midwifery as a Specialty Option, where a bridge has been created to allow the ADN nurse the opportunity to obtain a BSN followed by a Masters Degree in Nursing/ Nurse-Midwifery; and (4) the BA (Bachelor of Arts) to BSN to MS/MSN Nurse-

Midwifery Specialization which accepts non-nurse candidates and uses as streamlined curriculum towards both the nursing and nurse-midwifery credentials. The first two models of education are the most frequently selected by prospective students and reflect the largest percentage of nurse-midwifery graduates each year.

Variable 2 : Traditional versus Distance Education

Traditional refers to on-site, face to face education, with classroom didactic instruction, seminar participation, and coordination with clinical sites/Clinical Nurse-Midwifery Instructors. Clinical Nurse-Midwifery education may be provided by Educational Program faculty or contracted Clinical Faculty or a combination of both. Students may complete their clinical practicums within the same community as the traditional program and/or through contracted sites at variable distances from the traditional program. Traditional Nurse-Midwifery education is the most common model and the most frequently selected model of education.

Distance nurse-midwifery education enables the candidate to complete their didactic instruction independently while staying in their community, with minimal time spent on campus (often, only during a short orientation). Distance programs rely on credentialed, well-established, practicing nurse-midwives in the community who contract with the program to provide one-to-one clinical education and experiences. As of 2001, three distance education midwifery programs have obtained accreditation through the ACNM Division of Accreditation. As in other professions, distance education models are gaining in popularity among prospective students and among educators in midwifery. Traditional programs have begun to offer selected on-line courses as part of their distance education outreach to prospective students. In this study, distance education in nurse-midwifery

refers only to those programs that provide most and/or all of their education using the distance education model.

Variable 3: Nurse-Midwifery Practice Settings

Nurse-midwives practice in various settings. Therefore, students in traditional and distance education programs receive their clinical education in different settings. These settings include home birth practices, birth center practices, community hospitals (Level I and Level II), and Level III (tertiary) hospitals. Students may have the opportunity to gain clinical education in one, some, or all of these settings based on the educational program clinical arrangements.

Home Birth Practice Settings refer to practices where a midwife visits clients in their home during the prenatal months, attends the birth in the client's home, and provides immediate newborn care and postpartum care for a period of time post-birth. Home birth nurse-midwifery practitioners must meet the national guidelines for clinical practice, must have written agreements with consulting physicians, and are guided in the development of their home birth practices through the ACNM Committee on Home Birth Practices.

Birth Center Practice Settings refer to free standing centers for women and their families which provide care during healthy reproductive years and offer midwifery attended births in the free standing birth center. Care extends to early newborn and postpartum care and may also include additional well woman care related to contraceptive and gynecological care. Women arrive in labor and usually leave a few hours after the birth. The attraction to consumers of Free Standing Birth Centers includes the home-like atmosphere, birth experiences away from the hospital

environment, yet the Birth Center is prepared and equipped to handle major emergencies with timely transport to the contracted community hospital. Birth Centers meet national accrediting guidelines through the National Association of Childbearing Centers.

Community Hospital Settings – Level I and Level II hospitals are community hospitals that meet national guidelines and hospital accreditation policies and procedures in order to provide an environment for uncomplicated labor, deliveries, postpartum care, and uncomplicated newborn care as well as have the ability to handle emergency obstetrical events and minor neonatal complications. There is usually a house physician in residence, but not necessarily an obstetrician. Midwives practice in these settings in collaboration with an obstetrician (AHA list category) according to written protocols and guidelines for independent midwifery practice, collaborating practice for low to moderate risk pregnancies and births, as well as guidelines for referral and/or transfer to consulting obstetricians and/or medical specialists.

Level III Hospital (Tertiary) Practice Settings are teaching institutions, where medical residents receive their education and training through medical rotations and through specialty residencies. Reproductive care encompasses all levels of care from the uncomplicated pregnancy and perinatal experience (perinatal refers to care provided from evaluation during the pregnancy period through the birth, postpartum and early newborn period) to siginificant complications. Level III hospitals are accreditated and equipped to manage major obstetrical and newborn complications. Midwives working in Level III practice settings often navigate a complicated path involving crowded conditions, larger numbers of birthing clients requiring attention, larger and more complex midwifery practice groups, true high risk situations, as well as a plethora of

medical personnel ready to actively manage/intervene in the absence of the attending midwife.

Identification of Dependent Variables

Variable 1: Ideal Conceptualization of Exemplary Midwifery Process (Espoused Theory)

Exemplary Midwifery practices were described and defined in a 1999 Delphi Study (Kennedy, 2000). The researcher posed the question, "What is Unique and Exemplary About the Midwifery Model of Care?" to a group of expert midwives identified by leaders within the profession. After three rounds of enquiry on nurse-midwifery practices, the participants reached a consensus on the behaviors, and processes in practice that were than labeled as "Exemplary Midwifery Dimensions". In the final Delphi survey each of the dimensions received a rank of greater or equal to 6 on a 1 to 7 scale. These "Dimensions of Exemplary Midwifery" were then identified by the researcher and by the expert participants as a reflection of the espoused theory of midwifery. Newly graduated midwives who responded to the questionnaire were asked to respond to each of the dimensions along a similar scale as their own ideal conceptualization of exemplary midwifery or espoused theory. In this study, congruence was sought between the expert panel of participants in the Delphi Study and the graduate nurse-midwifery on the dependent variable, Ideal Conceptualization of Exemplary Midwifery (Espoused Theory).

Variable 2: Actual Emphasis of Exemplary Midwifery Process (Theory-in-Use)

In this study the scale on the identified dimensions of exemplary midwifery practice/process was expanded to include an observational scale, using the same 1 through 7 values. The scale of 1 to 7, ranged from "no emphasis" (1) to "high emphasis" (7) on 39 items reflecting dimensions of exemplary midwifery process.
Actual emphasis reflected the observed emphasis on the exemplary midwifery process during the last clinical experience/Integration

The Upper Scale represented Ideal Conceptualization of Exemplary Midwifery (Espoused Theory) and the Lower Scale represented Actual Emphasis of Exemplary Midwifery Process. New graduates responded to each of the dimensions on both scales, identifying how much emphasis they personally placed on the dimension and how much emphasis they observed was placed in actual practice by their clinical instructors. New graduates were asked to respond to their observation of clinical instructors as an aggregate experience rather than individualizing their observation to one particular clinical instructor.

Qualitative Data

Comments after Each Dimension

In addition to responding to the Ideal Emphasis and Actual Emphasis Scales on the Dimensions of Exemplary Midwifery Process, the students were given the opportunity to add qualitative comments after each dimensions. These comments could expand in more detail why they scaled the dimension the way they did, provide additional comments on the dimension itself, or provide more detailed example(s) of the dimension.

Unique Event Data

At the end of the questionnaire the student was invited to describe an event from their experience that reflected or commented on the dimension of exemplary midwifery process. It was anticipated that the unique event section would provide the researcher with clinical vignettes reflecting the presence or absence of exemplary midwifery processes/practice during a participant's clinical educational experiences (often called integration in educational programs).

Null Hypotheses

Null Hypothesis 1

There will be no difference between the respondent's espoused theory and that of the Delphi Experts on all 39 Dimensions. (espoused theory being expressed in the Ideal perception of exemplary midwifery Process)

Null Hypothesis

There will be no difference between the espoused theory of Delphi Experts and the degree of emphasis of the observation on Actual exemplary midwifery process by graduating students during the last clinical experience/integration all 39 dimensions

Null Hypothesis 3

There will be no difference between the Actual observed Exemplary Midwifery process during Integration and the Ideal espoused midwifery theory of respondents , using thematic dimension groupings.

Table 3.2

List of Independent and Dependent Variables

Independent variables	Dependent Variables
1. Type of Program attended Certificate Masters AD to BSN to Masters in Midwifery BA to BSN to Masters in Midwifery	1. Perception of the Ideal expression of exemplary midwifery process by graduating students during their final clinical experience 2.Actual observation of exemplary midwifery process by graduating students during final clinical experience
2. Distance education VS traditional Distance Traditional	3. Difference between degree of emphasis on exemplary midwifery process observed by students during their clinical experience and the ideal of midwifery process 4. Difference between the perception of Ideal of exemplary midwifery process of students and that of Delphi experts
3. Setting of clinical experience Home Birth Birth Center Level 1 and 2 hospital Level 3 hospital	5. Common themes extracted from the various "comments' added by the respondents

Null Hypothesis 4

That there will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home Birth Practice, Birth Center, Level 1&2 Hospital, or level 3 Hospital .

Null Hypothesis 5

That there will be no observational difference between the respondents' observation of exemplary midwifery practice process and types of educational programs, i.e. Certificate, Masters, BA to BSN to CNM, or AD to BSN to CNM

Null Hypothesis 6

that there will be no difference between the observed emphasis on exemplary midwifery practice process by respondents from Traditional Programs, (on site) versus Distance-Learning programs (web-based or others)

Instrumentation

Questionnaire Design

The questionnaire was designed based on a literature search on professional espoused theories and application of these theories in actual practice.

Argyris and Schon (1974) collected their data on espoused theory by direct observation of behaviors. They posited that the theory of action expressed verbally by people is a reflection of their espoused theory, even when their behavior does not reflect that theory. The theory reflected by the behavior is called theory-in-use and is often implicit. Any attempt at interpretation of the behavior by the actor often fails to elicit the hidden theory-in-use . In order to gather data on Nurse-Midwifery Implementation of "Espoused Theory" versus "Theory in use ", students were used as direct observers of exemplary midwifery process. Based on the 1999 Delphi Study discrete behaviors (dimensions of midwifery process) , reflective of nurse-midwifery's espoused theory were described. Students responded to each of the identified 39 dimensions using a scale of 1 to 7, from

No emphasis (1) to High emphasis(7). Students reflected on how much emphasis they personally placed on each of the dimensions (Ideal) and how much emphasis they actually observed while working with their clinical preceptors (Actual). Students were instructed to report on their observation as an aggregate of all of their preceptor experiences (integration).

The researcher then identified the 39 selected dimensions in the questionnaire as representing nurse- midwifery's espoused theory (Ideal Nurse-Midwifery Process). The student observed responses were identified as Theory-in-Use (Actual Nurse-Midwifery Process).

Additional Support for Design Questionnaire

Cohen and Manion (1996) state that "Surveys gather data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events" . In a book titled "Understanding Human Values", Milton Rokeach (1979) argued that survey questionnaire and content analysis are valid and widely used methods of value and attitude research.

The Survey Questionnaire: Practicing What we Preach

Practicing What We Preach was designed as two parts. Part I represented 39 questions related to the 39 dependent variables, Dimensions of Exemplary Nurse-Midwifery Process. Part II represented the independent variables

Part I of the questionnaire was developed by the investigator using the dimensions of Exemplary Midwifery Process as defined in a Delphi study of midwifery experts.

Discussion with the author of the Delphi study provided validity for the content of the questionnaire

While constructing the questionnaire, it was decided to allow each and every one of the dimensions expressed in the Delphi study to be present in this questionnaire, since each and every one of the dimensions represented a discreet and unique quality of expert midwifery process with only one deletion (#30) and one integration (# 19 and # 24)

The Delphi study resulted in a large number of behaviors/dimensions which the author developed into three organizational headings: The Process, The Outcomes, and Qualities and Traits. Outcomes are difficult for observer students to gauge since students spend only a short time in a particular setting and may not always observe or participate in determining the outcomes of midwifery interventions and/or behaviors. Qualities and Traits are subjective and difficult to operationalize reliably in a survey questionnaire. The dimensions included in the "Process" of exemplary midwifery were chosen because they reflected an "action" of nurse-midwifery process/practice and were congruent with Argyris and Schon's framework. of espoused theory and theory-in-use .

The "Process" dimensions in the study questionnaire reflected dimensions chosen at the end of the third round of the Delphi study that achieved an average of greater than 6.0 on a 1 to 7 scale on the original Delphi study. Other dimensions, also initially describing midwifery process, were rejected after the second round and not included in this questionnaire. This resulted in 39 Process questions, grouped according to Therapeutics, Caring and Professional Issues.

Cohen and Manion (1996) stated that, given a serious population, the length of the questionnaire might have little to do with the rate of return. The authors indicated that a

short survey might appear to the subjects as trivializing the content of the study. The researcher decided to include all of the 39 dimensions included under Process.
Each question offered the newly graduated student the possibility of answering what ideally was espoused as exemplary midwifery on the first line of the scale and what they actually observed during integration on the second line of the scale. Three additional lines were added at the end of each question offering the student the possibility to comment further, provide an example, or moderate the emphasis they selected.

Therapeutics, Caring and Professional Issues were mixed by sub-groups throughout the survey to avoid Order effect (Schuman and Presser ,1996) . Care was also taken not to reproduce the ranking of the Delphi study in the orders of the questions. It was thought that the emotional response elicited by a high ranking dimension might create a "rapport and salience" effect, where the passion elicited in one response creates a biased emotional reaction to the following question. (Schuman and Presser, 1996 ,p. 24) Professional issue questions were grouped together at the end, because of their Respondents were not cued as to the further grouping of the Dimensions of Process, namely Therapeutic, Caring and Professional .
The Dimensions of Process were grouped according to their common themes in the following manner:

Table3.4

Thematic Grouping if the Dimension of Exemplary Process

Groups	Dimensions/Questions
Therapeutic	
1 . Support the Normal Process of Birth	11,12,13,14,15,16,17,18,25
2. Vigilance and Attention to Details	1,2,3,4,5,6,7,8,9,10
Caring	
3. Respect the uniqueness of the Woman	22,23,24,26,29,31,32,33,34,35,
4. Respect the Woman through the Setting	19,20,21,27,28,30
5. Professional Issues	36,37,38,39

Adaptations to Dimensions

Adaptations to Process Dimensions were done by the researcher to better reflect a student's clinical experience . Adaptations to wording were discussed with the original researcher, who agreed that the changes did not cause conceptual changes on the original dimensions.

Examples

1.Dimension 2 "Maintains confidentiality" was qualified and changed to " keeping from discussing cases publicly and/or carelessly".

2. Dimension 19 "Considers cultural background" was collapsed into #24 "Avoids routinizing care" to avoid the use of almost similar clinical situations.

3. Dimension #30 "Maintains appropriate eye contact" was not used, as it is

impossible for a third party to observe and evaluate a pair's (midwife/client) eye contact.

The 39 remaining dimensions were presented as in the original Delphi study and were accompanied by a request to evaluate an ideal exemplary emphasis and an actual exemplary midwifery process observed during Integration, on a scale from 1 (no emphasis) to 7 (high emphasis). This scale was originally used in the second round of the Delphi Study. Space was provided at the end of Part I inviting the respondents to relate a particularly eloquent expression of exemplary midwifery practice (or not exemplary midwifery practice) as observed during their clinical experience (integration). Part II of the questionnaire collected information pertaining to biographical data and to the independent variables,

(a)Time of last experience, (b) Number of preceptors, (c) type of Midwifery education program , (d) Traditional/onsite or Distance program, and (e) Setting of clinical experience(s).

The questionnaire was also reviewed for clarity and content by a PhD prepared midwifery faculty member of another education program, experienced in midwifery research and education. The questionnaire was reviewed by a non-midwife with expertise in similar questionnaire design. No revisions were indicated.

Data Collection

The ACNM mailing list included 410 names of 2001 nurse-midwifery graduates. The questionnaire was printed on bright pink paper, (Fowler, 1993) , and a self -addressed

stamped return envelope was included. The envelope had a number from 1 to 410 in the right lower corner. The number was used by the researcher to identify respondents from the non-respondents. The actual questionnaire was anonymous and did not contain any identifying information about the respondent. A button bearing the words " Listen to Women" in white on blue background was included as a token gift for participating.

The questionnaire was pre-tested on a group of ten graduates from UMDNJ/SHRP University of Medicine and Dentistry of New Jersey/School of Health Related Professions, Nurse-Midwifery Program graduates of 1998. Graduates were asked to evaluate the questionnaire for clarity of wording and for ease and time needed to complete the survey. The researcher also evaluated the respondent's ability to follow directions and accuracy in interpreting the questions. Eight of the ten graduates answered. One graduate had a comment about the meaning of the term "dimension", which was not questioned by the other participants. The term remained in the study questionnaire, with clarification. All other dimensions were clear to the graduates, who could easily identify with the situational content of each question. Respondents took between 15 to 25 minutes to complete the survey. Additional time was needed for those respondents who elected to write longer comments. No changes were suggested. All of the pre-test respondents commented that the questions were clear and accurately reflected their own clinical experience(s).

Institutional Review

The questionnaire and study was approved by the Institutional Review Board of Seton Hall University. Consent to participate in the study was obtained through consent forms and by actual response to the questionnaire.

Pilot Study

Following IRB approval, the survey was piloted with 40 graduates from UMDNJ, from the year 1998-2000. Thirty one graduates responded. Twenty from New Jersey, 3 from Pennsylvania, 2 from Florida, 4 from New York and one each from Utah and Hawaii. Respondents did not make any recommendations or changes to the questionnaire. The researcher noted that there were fewer "comments" after each dimension question than expected. Since the "comments" that were written reflected general ideas, it was decided to include a check list question at the end of part II, as follows:

> " If you found that your clinical experience did not match what should have occurred, please indicate what factors might have contributed (please check all that apply): (a) Lack of follow up, (b) Not enough time, (c) Interference in hospital settings, and (d) Lack of private time (balance between professional and private life) .

These four situations reflected, verbatim, the comments expressed by respondents in the pilot study. It was hoped that the respondents would respond to a checklist if time prevented them from responding more fully in the comment sections or as an open-ended question.

Surveys were mailed during the winter of 2002 to the ACNM list of 410 newly certified (2001) midwives. As each questionnaire returned, the researcher crossed out the name on the ACNM mailing list and the envelope was immediately destroyed to maintain anonymity. The questionnaire was then assigned an identifying number for data processing and analysis.

At the end of 3 weeks, when the returns had almost stopped, a second mailing was sent, including a survey and a self-addressed stamped envelope, to the 200 newly graduated midwives who had not responded. A button was not included in the second mailing to limit expenses. The second mailing survey was printed on yellow paper. The same procedure was followed regarding returned questionnaires and envelopes, as well as the assignment of an identifying number for data processing.

As Questionnaires arrived, data was immediately entered using SSPS 7.5. Qualitative data, including both the comments and the unique experience(s), were entered on WORD for content analysis

Analysis of the Data

SSPS 7.5 was used for data analysis. All dependent and independent variables were given labels. Each of the 39 dimensions with location of emphasis on the Ideal Emphasis and the Actual Emphasis was entered for each respondent. Biographical and demographic data from Part II of the questionnaire was also included as variables in SSPS 7.5

Independent variables

Using the statistical program, the respondents were sorted into the following independent variables and labeled as follows:

1. Location of clinical setting:
    (a) Birth Center
    (b) Home Birth Practice
    (c) Level I &Level II hospitals

(d) Level 3 hospital

2. Type of educational programs:

(a) Certificate

(b) Masters

(c) BA to BSN to CNM

(d) ADN to BSN to CNM

3. (a) Distance learning program

(b) Traditional program

The independent variable data provide information about the distribution of the sample, and prepare data for hypothesis testing .

Descriptive Data

To obtain a clear picture of the sample and to help in conceptualizing the statistical tests, the frequency, mean and standard deviation for each of the 39 responses on the scale of 1 to 7 were computed for each Dimension of Ideal and Actual . A table for the 39 dimensions with the distribution of their frequencies, means, and standard deviations was created.(table 4.3)

The 39 dimensions were also ranked by order of frequency for high emphasis (6-7) on the Actual observation of exemplary midwifery by respondents. The five thematic groupings (see table 3.4) were also ranked by order of frequency. These results help inform which single dimension, or group of dimensions, reported as high in emphasis, were observed most frequently.

The difference between Actual frequency on high emphasis and the Ideal frequency on high emphasis were also ranked for each dimension. This result represents

the congruence between espoused theory (Ideal scale) and theory-in-use (Actual scale). The five Actual thematic groupings were similarly ranked by order of their difference with corresponding grouping on the Ideal scale.

Hypothesis Testing

Null Hypothesis 1

There will be no difference between the respondent's espoused theory and that of Delphi Experts on all 39 Dimensions.(Espoused theory being expressed in the Ideal perception of exemplary midwifery Process.)

In order to compare the new graduates and expert midwives on their espoused theory of exemplary midwifery , a One Sample T-Test will be used, comparing the means of each exemplary dimensions from the Delphi experts with the mean for "Ideal" emphasis of the respondent.

Null Hypothesis 2

There will be no difference between the espoused theory of Delphi Experts and the degree of emphasis of the observation on Actual exemplary midwifery process by graduating student during last clinical experience/integration on all 39 dimensions.

Hypothesis 2 will be tested using means, standard deviations and one sample t-test to compare the means of high emphasis of the Delphi Expertsfrom with the means on high emphasis for the Actual observation of exemplary process by the respondents.

Null Hypothesis 3

There will be no difference between the Actual observed process of Exemplary Midwifery during Integration and the Ideal espoused midwifery theory of respondents , using thematic dimension groupings.

Hypothesis 3 will be tested using a paired t-test comparing the means of each dimension. Comparing the means of the Ideal perception of the respondents with the mean of their Actual observation of high emphasis of exemplary midwifery process will inform us as to the congruence between their expectation and actualization of exemplary midwifery process during their clinical education.

Null Hypothesis 4

There will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home Birth Practice, Birth Center, Level I & Level II Hospitals, or Level III Hospital.

Hypothesis 4 will be tested using Analysis of Variance (ANOVA) to compare the means. Location of the significant difference , if any, will be further evaluated using Tukey HSD test .

Null Hypothesis 5

There will be no observational difference between the respondents' observation of exemplary midwifery process and types of educational programs, i.e. Certificate, Masters, BA to BSN to CNM, or AD to BSN to CNM

Hypothesis 5 will be tested using ANOVA. to compare the means. Location of the significant difference, if any, will be further evaluated using Tukey HSD test .

Null Hypothesis 6

There will be no difference between the observed emphasis on exemplary midwifery process by respondents from Traditional Programs, (on site) versus Distance-Learning programs (web-based or others).

Hypothesis 6 will be tested using an independent sample T-Test. The T-Test will be adapted for samples of unequal sizes. (Springthall, R, Basic Statistical Analysis)

For all of the hypotheses, analysis of the overall comparison of means as well as comparisons between the aggregate five Thematic groupings of Therapeutic (Vigilance and Support the normal), Caring (respect the unique and in the setting) and , Professional Issues (table 3.4) might shed more light and more targeted information on the observation of exemplary midwifery from respondents of different sites and educational programs .

Qualitative Data Analysis

Recurring themes were extracted from the qualitative data comprised of "Comments" and the "Unique experience" . These themes were matched to the level of emphasis computed from the statistical variables. A composite picture emerged, linking high or low emphasis on exemplary midwifery process with the themes expressed in the comments and the Unique experience.

Summary

This chapter has identified the sample used in this study, newly certified Nurse-Midwives in the year 2001 and why they was chosen to best inquire about the

observation of exemplary midwifery during Integration. Recency of recall as well as minimizing fear of reprisal accounted for choosing post certification recent graduates.

The questionnaire was constructed using 39 dimensions of exemplary midwifery process identified after three rounds of survey of expert midwives in a recent Delphi study. The questionnaire offered possibility to answer on a scale of 1 to 7, for two levels of expressions, one Ideal perception of midwifery process, and the other Actual observation during the last clinical experience (Integration).

Six null hypotheses that best clarify the extent of congruence between Ideal and Actual exemplary midwifery process and its implementation in various settings were formulated after careful review of the literature and variable identifications .

The respondents will be grouped according to the various educational programs they attended, and the location of their clinical setting

Using analysis and ranking of the measures of frequency , mean and standard deviation, the level on high emphasis for the Actual observation of exemplary midwifery process will be compared for all 39 dimensions. Using the difference between Ideal and Actual frequency on high emphasis, congruence will be measured.

The six null hypotheses will be tested using One sample T-test for Hypotheses number 1 and 2, paired T-test for hypothesis number 3, ANOVA for Hypotheses number 4 and 5, and finally, an independent sample T-test for Hypothesis number 6.

After review of the comments and the "last unique experience" a content analysis will be conducted to extract themes that will potentially shed light and clarify the responses on high or low emphasis given by the respondents for the Ideal perception and the Actual observation of exemplary midwifery process during their last clinical experience.

CHAPTER IV

FINDINGS AND RESULTS

Introduction

In this section, an analysis of all the data collected through the survey questionnaire returned by the newly certified nurse-midwives and compiled in two computer programs is reported. The difference, if any, between the Ideal perception of exemplary midwifery process by respondents and the expression of exemplary midwifery dimensions by experts is investigated. The extent to which exemplary midwifery process was observed by the new graduates is also discussed. The relationship, if any, between the extent of emphasis on the observation of exemplary midwifery reported by the newly certified nurse-midwives in various clinical settings and educational programs is analyzed and discussed. This description and analysis of the data is presented in five sections.

Section 1 provides an overview of the rate of the return , as well as the distribution of the respondents among the various clinical settings, types of educational programs and distance education versus traditional education . Section 2 discusses the descriptive findings from the questionnaire using frequencies and measure of central tendencies to provide an overview of the distribution ,and ranking of the Actual high emphasis on the observation of exemplary midwifery process during the respondents' last clinical experience. Rankings are described using all 39 dimensions first, then by five thematic groupings as described in Chapter III. Section 3 provides descriptive data on the

ranking of the congruence between Ideal perception and Actual observation of exemplary midwifery. Congruence is the difference between the percentage of high emphasis perceived as Ideal, and the percentage on high emphasis actually observed during clinical experience. Ranking is done using all 39 dimensions first, then by the five thematic groupings. Section 4 focuses on the results of statistical tests for the six Null hypotheses explicated in Chapter III. Section 5 provides a qualitative thematic content analysis of the comments and unique experiences described by the respondents. Finally, a summary of the findings and analysis is given.

Summary of the Survey Return and Distribution

The mailing labels received from the ACNM provided 413 addresses for new midwives who had received a certifying number in the year 2001. Of these 413, three midwives were from foreign countries, two from Canada and one from Israel . Since it was not possible to include a stamped self-addressed envelope for the three foreign midwives, which may have biased their participation , it was decided not to include the three newly graduated foreign midwives.

Surveys were sent to 410 newly graduated midwives, distributed in all 6 ACNM regions, including Puerto Rico and the Virgin Islands (Table 4.1).

The first mailing, which included a gift button and was printed on bright pink paper, yielded 199 responses, a return of 49% . The first mailing yielded returns greater than 40% for each region, which , according to survey methodology, allows adequate representation (Babbie, 1990) . In order to increase the response to at least 50%, and hopefully raise the comparatively low percentage of return number for region V (39%) , a second mailing was sent to all non-respondents.

Table 4.1

Distribution of New Graduates 2001 Respondents per Regions

Region	No of Grads	Respondents	Respondents as % Of region	Regional response % of total respondents*
Region I	38	21	55	9
Region II	79	50	63	20
Region III	68	41	60	17
Region IV	83	50	60	20
Region V	77	43	56	18
Region VI	65	40	62	16
Total	410	245	--	100

Note: * Total respondents N=245

The survey was printed on light yellow paper, both for continuity of method and for ease of tracing second round respondents. The follow up letter reminded the potential participants of the importance of their participation and of the confidential nature of this survey. (appendix B) . A stamped self-addressed return envelope, without the gift button, was included. The second mailing resulted in 46 additional responses, which increased the total numbers in each of the ACNM regions (Table 4.2). Table 4.2 represents the final sample sized used for analysis. The final return rate was 60%.

The respondents from the six ACNM regions had received their midwifery education at the following types of midwifery education programs (Table 4.3). Only one (0.4%) respondent with an Associate degree in nursing received her midwifery education

in a program offering the option to obtain a bachelor in nursing and a certification in midwifery to candidates with an associate degree in nursing.

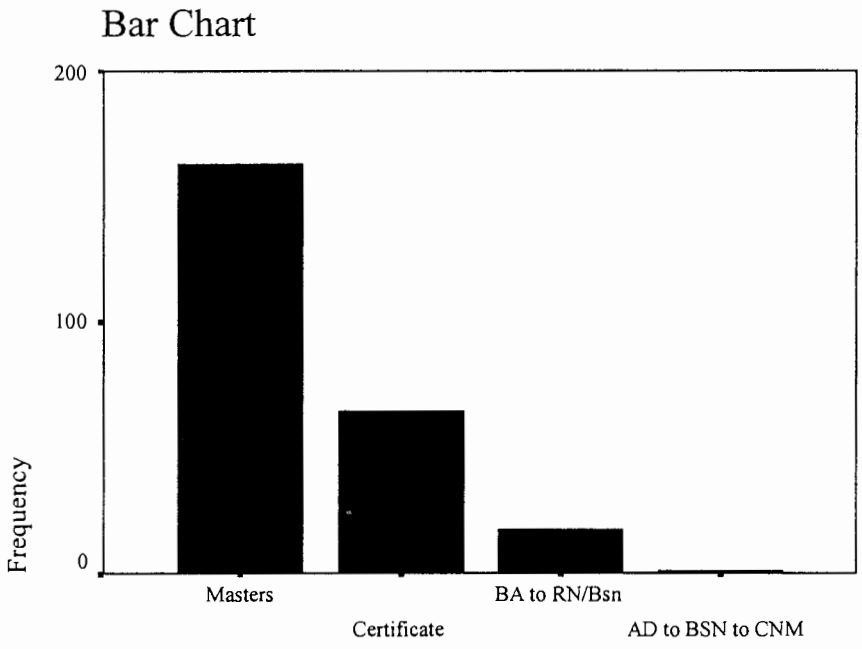
Table 4.2

Distribution of Survey Return Across the Independent Variables

Independent Variables	No. of Returns	% Returns
Types of Programs		
ADRN to BSN to CNM	1	.4
BA to BSN to CNM	17	6.9
Certificate	64	26.1
Masters	163	66.5
All Programs	245	100
Distance/Traditional		
Distance	76	31
Traditional	169	69
All Modes	245	100
Clinical Settings :		
Home Birth Practice	7	2.9
Birthing Center	25	10.2
Level 3 hospital	93	38
Level 1&2 hospital	120	49
All Settings	245	100

Seventeen (6.9%) respondents attended programs that offered admittance to non-nurses, and streamlined the nursing education and the midwifery education under one program. Sixty four respondents (26.1%) attended a Post BSN Certificate Program and 163 (66.5%) graduated from a Masters Program (Table 4.3)

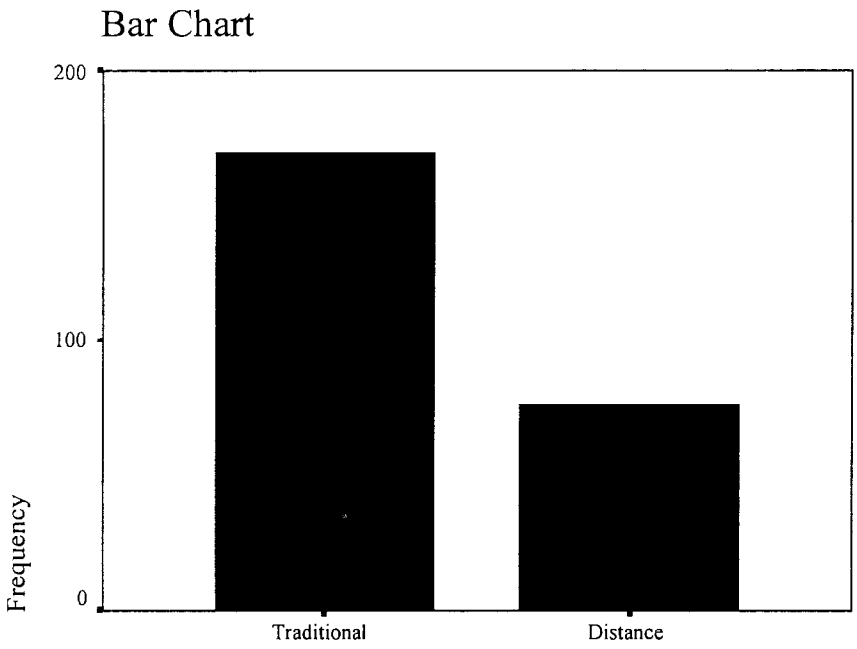
Table 4.3



All respondents (100%), n=245, answered the question regarding type of delivery of their education, either Traditional (on-site) or Distance (web or mail) .

Table 4.4 demonstrates, seventy six (31%) first year grads used the Distance Learning option to obtain their certificate in midwifery . One hundred and sixty nine (69%) chose the more Traditional on-site option.

Table 4.4

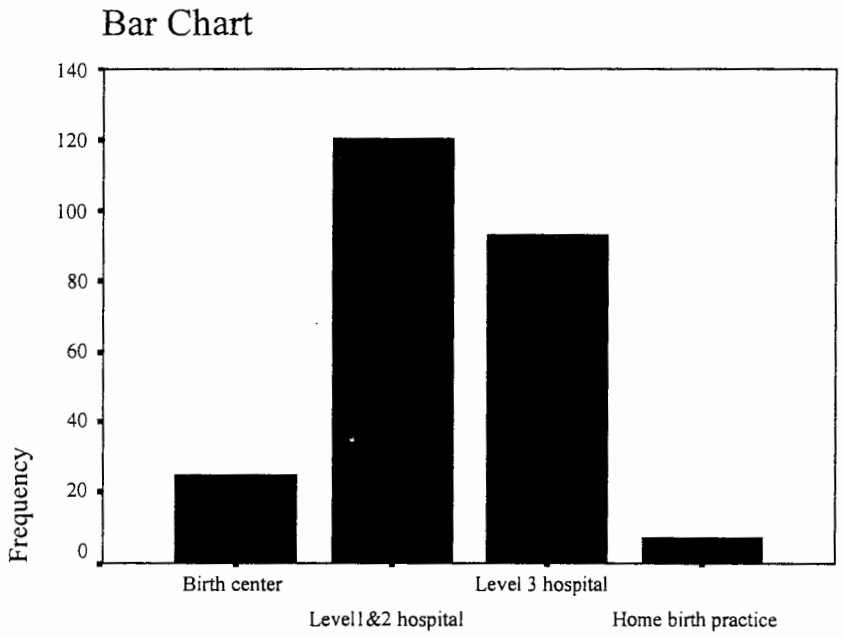


Traditional vs Distance

Midwives practice in various settings: Birth Centers, Home Birth practice, Level 1and Level 2 (community) hospitals, and Level 3 (perinatal centers) hospitals. Midwifery students receive their clinical experience in any of the four practice settings, depending on availability, their preference, or their program directors' decision. Respondents received their final clinical experience at the following practice sites: 25 (10.2%) in Birth Centers (10.2%); 7 (2.9%) in a Home birth practice; 93 (38%) in Perinatal centers (Level 3) , which are often located in the inner cities and cater to complications as well as normal births; and 120 (49%) completed their clinical in a Level 1 or Level 2 hospital. The greatest number of respondents completed their final clinical experience (integration) at Level 1 or Level 2 hospitals (Table 4.5)

Table 4. 5

Distribution of respondents for Final Clinical Experiences Across Practice Sites



It is impossible to determine from the mailing list what the educational backgrounds were for all of midwifery graduates in 2001. Only the educational backgrounds of the respondents to the questionnaire are known. However, the distribution of the respondents across the clinical sites roughly reflects the distribution of midwifery practice sites in this country. More than 80% of actively practicing midwives work in hospitals with the next largest group practicing in Birth Centers. Only a small fraction of midwives (about 2%) have home birth practices.

Descriptive Data Analysis of the Actual Observation on all Dimensions

In the survey questionnaire, each dimension of exemplary midwifery process was assigned a value of 1 to 7, with 1 meaning no degree of emphasis and 7 meaning a high degree of emphasis. A similar scale was used in the Delphi study conducted by Kennedy (2000) which provided the dimensions of exemplary midwifery process used in this study. In the Delphi study, expert midwives used a scale from 1 to 7 , with 6 and 7 (high emphasis) used to rank the most representative behaviors describing exemplary midwifery. The current study defined the scale and ranking in a similar fashion. Those dimensions of exemplary midwifery observed or perceived with an emphasis of 6 to 7 were identified as high emphasis; those observed/perceived with an emphasis of 4 to 5 as moderate emphasis, and those observed/perceived with an emphasis of 1 to 3 as low emphasis. This allowed the researcher to make comparisons of the rankings given each of the 39 dimensions by the newly graduate midwives with that of the rankings given each of the 39 dimenisons by exemplary midwives from the Delphi study.

Overall Description of all 39 Dimensions

Table 4.6 describes the overall scale values , frequencies, mean and standard deviation for emphases 1 to 3, 4 to 5, and 6 to 7, taking one dimension at a time, for all 39 dimensions. The data to the left of the table describes emphases on Actual observations, data found in the middle part of the table describes emphases on Ideal perception and data farthest to the right describe the difference between Ideal and Actual, using the overall mean, and the difference in the frequencies for high emphasis (6-

7)between Ideal and Actual. Table 4.6 displays all 39 dimensions as they are clustered under the themes of Therapeutic, Caring, and Professional Issues.

Tqble 4.6
Overall Scale values
Frequencies , Percentage ,mean and Standard Deviations (N=245)

Dimensions	N	Actual						Ideal						Difference		
		1-3	4-5	6	7	X	SD	1-3	4-5	6	7	X	SD	Xi-Xa	D7	D6-7
Therapeutic: Vigilance																
1. Being vigilant and paying Attention to details	245	1.2	35.9	33.9	29.0	5.76	1.07	.4	5.3	24.5	69.8	6.62	.65	.87	40.8	31.4
2. Documenting care very well	245	10.2	40.8	24.5	24.5	5.73	1.12	.8	6.5	19.6	72.7	6.63	.71	.90	48.2	43.3
3 D oing thorough and on-going Assessments	245	2.9	31.8	35.9	29.4	5.80	1.06	0	5.7.	23.7	70.6	6.64	.62	. 85	41.2	29
4 Following up on care	244	11.4	36.4	28.6	22.4	5.32	1.45	0	6.5	20.8	72.2	6.65	.61	1.32	49.8	42
5....Working to prevent problems	241	9.3	41.2	27.3	20.4	5.36	1.26	.4	6.1	24.9	66.5	6.60	.68	1.23	46.1	43.7
6. Practicing within a circle of Safety	244	3.2	25.3	29.8	41.2	5.95	1.18	.4	3.7	17.1	78.0	6.74	.56	.79	36.8	24.1
7. Consulting and referring Appropriately	243	2	21.6	32.2	43.3	6.09	1.03	.4	5.3	21.2	72 2	6.65	.71	.56	28.9	17.9
8. Being timely in clinical Actions	244	3.6	32.7	32.2	31.0	5.76	1.16	.4	9.4	26.1	63.7	6.53	.71	.77	32.7	26.6
9 Remaining alert to a changing clinical picture	244	8	20.8	39.2	38.8	6.10	.91	0	3.7	18	77.6	6.74	.53	.64	38.8	17.6
10. Being adept at listening to one's own intuition when responding to the woman's changing needs	245	11	38.3	29.4	21.2	5.33	1.35	.8	13	22	62.9	6.45	.89	1.12	41.7	34.3

DIMENSIONS	N	Actual						Ideal						DIFFERENCE		
		1-3	4-5	6	7	X	SD	1-3	4-5	6	7	X	SD	Xi-Xa	D7	D6-7
Therapeutic: Support the Normal Process:																
11. Supporting the normal process Of birth as a healthy physiologic Event, not as an illness	245	11.4	34.3	20.4	33.9	5.45	1.53	.4	1.2	11.8	86.5	6.83	.54	1.39	52.6	44
12....Intervening only if necessary And appropriate	245	16	45.7	17.6	20.8	4.97	1.56	.4	6.1	14.3	79.2	6.71	.63	1.74	58.4	55.1
13. Being patient, not hurrying	245	16.7	51.4	16.7	15.1	4.86	1.41	.8	12.2	24.9	62.0	6.46	.82	1.59	46.9	55.1
14. Using low technology approaches when possible	245	18.3	49.4	18.0	14.3	4.81	1.47	.4	9.8	25.7	63.7	6.51	.78	1.69	49.4	57.1
15. Drawing on a wide range Of resources to tailor a woman's needs	245	16.3	53.9	16.3	13.5	4.85	1.40	.4	15.1	26.5	58.0	6.38	.87	1.54	44.5	54.7
16 Considering all options when Deciding on a clinical Management	245	8.1	44.5	32.7	14.7	5.27	1.20	.8	3.7	29.0	66.5	6.60	.65	1.34	51.8	48.1
17. Drawing on natural resources when assisting the woman, such as ambulation, nutrition	245	15	33.9	21.2	29.8	5.25	1.63	.4	5.3	20.8	73.1	6.66	.66	1.42	43.3	42.9
18.Personalizing care, avoiding a one-fir-all approach	245	10.2	40.8	24.5	24.5	5.30	1.44	.4	. 4.5	17.6	77.6	6.71	.63	1.40	53.1	46.2

Note: D7 refers to the difference between Ideal value 7 and actual 7
D6-7 refers to the difference between Ideal values 6 + 7 and Actual 6+7

DIMENSION	N	Actual						IDEAL						DIFFERENCE		
		1-3	4-5	6	7	X	SD	1-3	4-5	6	7	X	SD	Xi-Xa	D7	D6-7
25. Adopting a wholistic Approach to the care of the Woman	243	12.3	49.4	22.9	14.7	5.00	1.37	4	9.8	23.7	65.7	6.54	.74	154	51	51.8
Care: Respect the woman in setting:																
19.Maintaining a supportive presence in labor staying with the woman as she desires	245	18.4	38.4	18.4	24.9	5.05	1.60	0	4.9	23.3	71.4	6.66	.61	160	46.5	51.4
20. Providing positive encouragement and validation	245	4.8	20.8	27.3	46.5	6.02	1.24	.4	3.7	16.7	79.2	6.74	.58	.72	32.7	22.1
21. Creating an environment that is respectful, even under often dismal external circumstances	243	2.8	20.8	32.2	43.3	6.06	1.11	.4	2.8	13.1	83.7	6.79	.57	73	40.4	21.3
27..Being accessible and available To the woman	242	6.5	31	29.0	32.2	5.69	1.28	.8	5.7	20.8	71.4	6.63	.72	93	39.2	31
28. Making an effort to provide Adequate time to the woman's Needs	242	10.1	38	30.2	20.4	5.37	1.33	.4	6.9	19.2	71.4	6.64	.69	127	51	40
30. Obtaining informed consent	242	8.2	24.1	18.8	47.8	5.83	1.50	0	5.2	23.7	70.6	6.65	.83	82	22.8	27.7

Note: D7 refers to the difference between Ideal value 7 and actual 7
D6-7 refers to the difference between Ideal values 6 + 7 and Actual 6+7

DIMENSIONS	N	Actual						IDEAL						DIFFERENCE		
		1-3	4-5	6	7	X	SD	1-3	4-5	6	7	X	SD	Xi-Xa	D7	D6-7
Care: Respect the Uniqueness:																
22. Respecting the woman and her family, understanding the family's primary importance to the woman's support	245	3.7	20.9	32.2	42.9	6.03	1.12	4	4.1	15.9	79.2	6.74	.57	72	36.3	20
23. Maintaining confidentiality keeping from discussing cases publicly and/or carelessly	245	6.5	24.4	22.4	46.5	5.90	1.39	.8	2.0	13.9	83.3	6.78	.57	.89	36.8	28.3
24. Avoiding routinizing care Adapting to the woman's Cultural and emotional Needs	245	10.6	39.6	27.8	22.0	5.31	1.39	4	6.9	20.4	72.2	6.63	.69	1.32	50.2	42.8
26. Involving the whole family And significant others In her care, as much as she wishes	243	8.1	21.8	27.8	31.4	5.63	1.30	.4	5.7	25.7	67.8	6.61	.65	.98	36.4	34.3
29. Providing thorough education And accurate information based On the woman's needs	243	7.3	27.1	26.1	28.6	5.56	1.29	8	4.1	14.7	79.2	6.74	.61	1.18	50.6	39.2
31. Listening carefully to the woman's voice and responding appropriately	245	6.5	25.9	28.2	29.0	5.60	1.29	2	4.5	15.1	77.1	6.59	.77	1.0	48.1	35
32..Working as a partner with the Woman	245	7.7	36.9	24.9	31.4	5.58	1.33	4	7.8	20.4	71.0	6.62	.72	1.05	39.6	35.1

Note: D7 refers to the difference between Ideal value 7 and actual 7
D6-7 refers to the difference between Ideal values 6 + 7 and Actual 6+

DIMENSIONS	N	Actual						IDEAL						DIFFERENCE		
		1-3	4-5	6	7	X	SD	1-3	4-5	6	7	X	SD	Xi-Xa	D7	D6-7
33.Helping the woman draw on Her inner strength	244	9.8	43.6	24.5	21.6	5.67	1.38	.4	8.6	16.7	73.9	6.64	.70	1.37	52.3	44.5
34. Advocating for the woman's Needs	244	6.1	33.4	26.9	33.1	5.66	1.30	0	5.3	17.1	77.6	6.71	.60	1.05	44.5	34.7
35. Being gentle with the woman When needing to do Uncomfortable procedures	245	1.6	15.5	27.8	55.1	6.30	.98	4	2.8	12.2	84.5	6.79	.57	.49	29.4	13.8
Professional Issues :																
36. Updating one's own professional Knowledge through journal Reading and regular attendance At conferences and seminars	245	8.9	34.7	25.7	30.6	5.54	1.35	.4	5.3	20.0	74.3	6.66	.71	1.12	47.7	38
37. Using reflection to understand and improve clinical practice	240	15.5	44.1	21.2	17.1	5.02	1.48	1.6	10.9	29.8	55.1	6.34	.94	1.32	38	46.6
38. Seeking peer review mechanism To enhance the quality of Clinical practice	242	25.2	35.9	19.6	18.0	4.69	1.76	2.0	11.8	27.3	57.6	6.38	.93	1.69	39.6	47.3
39. Bringing balance to personal And professional life	245	33.5	35.9	14.7	15.1	4.32	1.87	2.0	7.3	18.8	70.6	6.55	.93	2.23	55.5	59.6

Note: D7 refers to the difference between Ideal value 7 and actual 7
D6-7 refers to the difference between Ideal values 6 + 7 and Actual 6+7

Overall Ranking of Actual Observations Using all 39 Dimensions

Table 4.7 ranks all 39 dimensions by frequency of responses to high emphasis (6-7) in observation of Actual exemplary midwifery process. The dimension that ranked highest was "Being gentle", with a frequency of 82.9% on observed high emphasis and the dimension that ranked lowest was " Having a balanced life" with a frequency on high emphasis observed at 29.8% .

Only seven dimensions were observed with a frequency on observed high emphasis greater than 70%. Eight dimensions ranked lower with a frequency less than 40% , meaning that they were observed with high emphasis only 40% or less of the time (see table 4.7).In the overall analysis of the data, it was more effective to look at the ranking of the five thematic groupings previously introduced in chapter III . The full descriptive narrative for all dimensions can be found in Appendix E . Grouping the dimensions according to their common themes before rankings allows the trends to emerge and potentially indicates the common congruence or lack thereof of the dimensions.

Table 4.7

Ranking for all Actual Dimensions for all Respondents with Emphasis Equal or Greater than 6

Ranking Actual	Dimension	% of Actual Responses > 6
1	Being Gentle(35)	82.9
2	Remaining alert (9)	78
3	Respectful environment(21)	75.5
3	Consulting(7)	75.5
5	Respect family(22)	75.1
6	Provide validation(20)	73.8
7	Circle of safety(6)	71
8	Maintain Confidentiality(23)	68.9
9	Informed Consent (30)	66.6
10	On-going Assessments(3)	65.3
11	Being Timely(8)	63.2
12	Being Vigilant(1)	62.9
13	Being Accessible(27)	61.2
14	Advocating for needs(34)	60
15	Involving family in care(26)	59.2
16	Follow up on Care(4)	57
17	Working as a Partner(32)	56.3
17	Updating Knowledge(36)	56.3
19	Provide Education (29)	54.7
20	Support Normal Birth(11)	54.3
21	Listening Carefully(31)	51.2
22	Use Natural Resources(17)	51
23	Listen to Intuition (10)	50.6
23	Provide Time(28)	50.6
25	Avoiding Routinizing(24)	49.8
26	Documenting well(2)	49
26	Personalizing care(18)	49
28	Prevent Problems (5)27	47.7
29	Consider all Options(16)	47.4
30	Draw Inner Strength(33)	46.1
31	Maintain Presence(19)	43.3
32	Appropriate Intervention(12)	38.4
33	Using Reflection (37)	38.3
34	Wholistic approach (25)	37.6
35	Seeking peer-review (38)	37.6
36	Low Tech Approach (14)	32.3
37	Being Patient (13)	31.8
38	Wide Resources(15)	29.8
38	Having Balanced life (39)	29.8

Table 4.7, while describing and ranking the frequency of all 39 dimensions as Actual observed ,does not inform with respect to the thematic groupings of the 39 dimensions. Dimensions were grouped (clustered) according to overarching themes in the Delphi study (see Table 3.4).

Table 4.8 ranks the five thematic groupings by order of the frequency of observed high emphasis . The thematic grouping of "Vigilance and attention to details" was ranked at the highest frequency for high emphasis at 62%. The thematic grouping "Respect the woman through the setting" was ranked at 61.83% and the thematic grouping "Respect the uniqueness of the woman" was ranked at 60.4%.

Table 4.8

Frequency Ranking of the Five Thematic Groupings of Actual Observed Emphasis

Groupings	Actual observed frequency of high emphasis
Therapeutic: Vigilance and attention To details	62.0%
Care: Respecting the woman through the setting	61.83%
Care: Respecting The uniqueness Of the woman	60.42%
Therapeutic:Support the normal process of birth	41.29%
Professional	40.5%

Table 4.8 ranks Care: "Support the normal process of birth" next to last with a frequency of only 41.29% and Professional Issues last at 40.5% on the observed high emphasis by the respondents.

If one looks at the dimensions represented in these thematic groupings (table 4.6) and their ranking for high emphasis , a trend emerges:

The thematic grouping "Vigilance and attention to details" is an aggregate of 10 dimensions, six of which ranked higher than 60% and eight out of the ten higher than 50% on the overall scale for emphasis. For the thematic grouping "Respect the woman through the setting" , four of the six dimensions ranked higher than 60% on high emphasis. For the thematic grouping "Respect the uniqueness of the woman" also ranked more than half its dimensions higher than 50%.

The thematic grouping "Support the normal process of birth" was an aggregate of nine dimensions, seven ranked lower than 50% , none above 55%.

When analyzing the thematic group "Support the normal process of birth" one is compelled to extract the frequency of low to no emphasis (1 to 3) observed by the respondents for those same nine dimensions that ranked below 55% on high emphasis. Table 4.9 ranks the nine dimensions of "Support the normal process of birth" by order of frequency on the low to no emphasis in the actual observation of exemplary midwifery process.

Table 4.9

Frequency of Low Emphasis of the Dimensions of "Support the Normal"

Name and Number of Dimension	% of no to low emphasis Observed (1-3)
14 "Low tech approach"	18.3
13 " Being patient"	16.72
15 " Uses wide resources"	16.3
12 "Intervenes only if necessary"	16
17 "Uses natural ways"	15
25 " Wholistic approach"	12.3
11 "Support the normal process of birth"	11.4
18 " Personalizes care"	10.2
16 "Considers all options"	8.1

The table 4.9 identifies which of the dimensions are observed with the least emphasis by the respondents Lowest emphasis was given to 'Low tech" and "Being patient", 18.0% and 16.7% respectively.

Using low technology approaches can be difficult in the modern hospital setting where most midwives practice and where high technology is often expected In hospital settings, low technological approaches are not considered a viable option for many births. Busy practices and the high volume of laboring women usually prohibit the low technology approach. Low technology requires patience. "Being patient", however, espoused as

essential to the respectful unfolding of the natural process of labor and birth, is observed with a low to no emphasis by nearly 17% of the respondents. This result raises the question of "what are the obstacles" to the implementation of this essential espoused dimension of patience?

All of the above dimensions (" Support the normal")of exemplary midwifery are espoused as hallmarks of midwifery care , not only by standard midwifery definition, but also by the Delphi panel of expert. (Kennedy, 2000)

A closer look at the comparison(s) between the the respondents ideal perception and actual observation exemplary midwifery during integration might shed some light on the question of congruence or incongruence between Ideal perception and the actual implementation of espoused theory in actual practice.

The Difference in Frequency of High Emphasis between the Ideal Perception of Exemplary Midwifery Process and the Actual Observation of respondents:

The dimensions of Ideal exemplary midwifery processes which were ranked by expert midwives at 6 or higher (high emphasis) in the Delphi study (Kennedy, 2000) were also used used and examined in this study. Midwives give deep allegiance to these 39 dimensions as a set of beliefs defining their espoused theory. Respondents also expressed their espoused theory by answering on a scale of 1 to 7, putting a personal emphasis on their perceived Ideals of exemplary midwifery process

Theory-in-use has been defined as being represented as the behaviors directly observed by the respondents of their clinical educators, as an aggregate , in the respondent's final clinical experiences/integration. Respondents placed an emphasis of 1 to 7 on the Actual scale for each of the 39 dimensions of exemplary midwifery process.

Congruence by Difference in Overall Means

In order to measure the congruence between the Ideal perception and the Actual observation , the difference in the frequency for high emphasis was computed and ranked for each dimension . Table 4.10 offers a ranking from 1 for most congruent with the smallest difference between the frequencies of observed high emphasis to 39, or least congruent with the widest gap between the perceived and observed frequencies.

A full descriptive analysis of the overall mean emphasis ranking for the difference between Ideal perception of exemplary midwifery process and the Actual observation of exemplary midwifery process by the respondents for all of the 39 dimensions is presented in Appendix H.

Levels of congruence, as defined in chapter 1 , are measured according to the following classification:

Very low congruence	> 50% difference
Low congruence	>40 but < 50% difference
Moderate congruence	>20%, but < 40% difference
Higher congruence	>10%, but < 20% differenc
Highest congruence	< 10% difference

Four of the 39 dimensions were ranked at higher congruence for the observed emphasis. Seven dimensions ranked at the lower end of the spectrum with a gap higher than 50%. This gap represents very low congruence for observed high emphasis of exemplary midwifery process.

Table 4.10
The Difference in the Frequency of High Emphasis between Ideal Perception of Respondents and the Actual Observation of Exemplary Midwifery

Rank	# Dimension	Difference Ideal-Actual for High Emphasis in %
1	Being Gentle(35)	13.8
2	Remaining Alert(9)	17.6
3	Consulting (7)	17.9
4	Respecting Family(22)	20.0
5	Respectful Setting(21)	21.3
6	Providing Validation(20)	22.1
7	Circle of safety(6)	24.1
8	Being Timely(8)	26.6
9	Informed Consent(30)	27.7
10	Maintain Confidentiality(23)	28.3
11	On-Going Assessments (3)	29.0
12	Being Accessible(27)	31.0
13	Being Vigilant(1)	31.4
14	Involve Family(26)	34.3
14	Listen to Intuition(10)	34.3
16	Advocating for Needs(34)	34.7
17	Listen Carefully(31)	35.0
18	Working as a Partner(32)	35.1
19	Update Knowledge(36)	38.0
20	Provide Education(29)	39.2
21	Making Time(28)	40.0
22	Follow up(4)	42.0
23	Avoid Routinizing(24)	42.8
24	Draw on Natural(17)	42.9
25	Documenting Well(2)	43.3
26	Prevent Problems(5)	43.7
27	Support the Normal(11)	44.0
28	Draw Inner Strength(33)	44.5
29	Personalize Care(18)	46.2
30	Use Reflection(37)	46.6
31	Seeking Peer-Review (38)	47.3
32	Consider all Options(16)	48.1
33	Supportive Presence(19)	51.4
34	Wholistic Approach(25)	51.8
35	Wide range of resources(15)	54.7
36	Being Patient (13)	55.1
36	Appropriate Interventions(12)	55.1
38	Using Low Tech(14)	57.1
39	Balanced Life(39)	59.6

A look at the five thematic groupings described in section 2 of this chapter helped identify which groupings of dimensions are responsible for the various levels of congruence

Congruence by Thematic Groupings

Table 4.11 ranks the five groupings by order of the difference between Ideal and Actual frequency for observed high emphasis (6 and 7). The thematic grouping "Vigilance and attention to details" was most congruent with a 30.99% difference in the frequency between Ideal and Actual rankings. This thematic grouping was most concerned with themes of safety in practice, proper assessment and consultation, and appropriate documentation. "Respect of the woman through the setting" and "Respect the uniqueness of the woman" ranked next at 32.2% and 32.7% respectively and were practically identical for congruence between Ideal and Actual.

The individual dimensions of respect , under the thematic groupings of " Respect the uniqueness of the woman" and " Respect the woman through the setting" ranked above 20 with a difference of less than 40%, thus ranking in the moderate to higher congruence range (table 4.10).

Professional Issues ranked fourth, next to last, at 47.87%. "Support the normal process of birth" ranked last at 50.5%. This difference of 50.5% between Ideal perception and Actual observation on "Support the normal process of birth" resulted in this grouping being the least congruent grouping. While "supporting the normal process of birth" is idealized and espoused, in this study the respondents observed this exemplary midwifery process in actual practice at the lowest frequency.

Table 4.11

Ranking of The 5 Groupings by Order of the Difference Between the Mean of the Observed High Emphasis

Grouping	Actual Mean High Emphasis	Ideal Mean High Emphasis	Difference Ideal- Actual
Therapeutic: Vigilance and Attention to Details	61.42%	92.4%	30.99%
Caring: Respect the Woman through The setting	61.83%	94.08%	32.2%
Caring: Respect the Uniqueness of The woman	61.02%	93.79%	32.77%
Professional Issue Therapeutic Support the Normal process	40.50%	88.36%	47.87%
	41.29%	91.82%	50.54%

Respecting the normal process of birth is reflected by avoidance of unnecessary interventions, patience, use of natural resources, and the use of low only when needed or appropriate. Both the Delphi experts and the new graduate midwives reported these dimensions as high emphasis (greater than 90%) on the Ideal scale. However, the Actual observation of "Respecting the normal process of birth" for high emphasis was only 41.2% (table 4.11). The difference resulted in a gap greater than 50% reflecting the least congruence between Ideal and Actual for "Respecting the normal process of birth". This result is disturbing since respecting the normal process of birth is a hallmark of midwifery care, as expressed in the Core Competencies for Midwifery Practice (Appendix D).

One observation that may account for this lack of congruence between the ideal and the actual comes from the respondents added comments on the survey. Comments were content analyzed for frequency of descriptors or examples. Descriptors were given thematic labels Maybe – Descriptive categories were identified through content analysis. Descriptive comments that were identified by the respondents as positive experiences and supportive of espoused theory were categorized as "positive descriptors (+)". Descriptive comments that were identified by the respondents as negative experiences and non-supportive of espoused theory were categorized as "negative descriptors (-)". Descriptive comments that were mixed in their responses, describing both a positive and negative experience in the same comment were categorized as "mixed or qualifying statements (+/-). Table ___ was created using column headings of "+", "-" and "+/-" for "positive descriptors", "negative descriptors", and ""mixed or qualifying descriptors" respectively. The lack of congruence between ideal and actually observed midwifery process of respecting the normal process of birth was examined through content analysis of all of the respondents added comments. The most frequently occurring comment about actual observations of clinical practice identified "speed" and "environments of practice" as negative descriptors, preventing the clinical educators from practicing their espoused theory. Environments of practice were most frequently described as dictating the level and types of interventions used to manage patient care. Lack of time and busy services were the most frequent reasons for abandoning the "luxury of patience". The respondents described unnecessary interventions were the result of a combination of factors: individual midwifery styles of practice, desired by the patient, or as a result of pressure

from the hospital/medical environment and reflected in protocols and/or policies – both overt and covert.

When describing the absence of a wholistic approach to care and the limited use of low technology or diverse resources, respondents described that few opportunities were available to use fetoscope , ambulation , hydrotherapy, position change or other modalities in assisting with the progress of labor. Again, environment dictated practice, and the high technological therapies offered in hospitals left little room to expand other modalities.

Testing of the Six Null Hypotheses

Testing Hypothesis 1

There will be no difference between the respondents' espoused theory and that of the Delphi Experts on all 39 Dimensions. (espoused theory being expressed in the Ideal perception of exemplary midwifery Process)

Survey participants were asked to answer each of the dimensions of exemplary midwifery process as to their perception of Ideal emphasis, on a scale of 1 to 7. Experts from a previous Delphi study had already identified those same dimensions of exemplary practice and also scaled each of the dimension with a value of 1 to 7.(Appendix H) Only the dimensions that received a value of 6 or greater both by the respondent and by the Delphi experts (high emphasis) were singled for this analysis (see table 4.12).

The t-test identified which of the 39 dimension(s) , if any , was endorsed differently by the Delphi experts and the newly graduate midwives. Applying the means for each of

the Ideal dimension , a t-test reveals that our hypothesis is partially rejected and partially accepted.

It is accepted for 12 of the 39 dimensions (table 4.12) ;we feel confident that the student sample share a vision of exemplary midwifery with the Delphi experts on these dimensions. Table 4.12 describes the results of the t-test for all of the 39 dimensions. an asterix identifies the dimensions with a difference that attains statistical significance.

The Hypothesis was rejected for 27 of the 39 dimensions: In 22 of these dimensions, however, the respondents' overall mean for the Ideal perception of Exemplary midwifery process surpassed than that of the Delphi experts , reassuring us that the respondents sample placed an even higher ideal emphasis on those dimensions of exemplary midwifery.

Table 4.12

One Sample t-test comparing the means on emphasis for Exemplary Midwifery Process given by Delphi Experts to the Ideal Perception reported by Respondents.

Dimension	XS	XD	t (2-tailed)	df	sig.
1-Vigilance	6.63	6.41	5.156	244	.000*
2-Documenting	6.63	6.10	11.767	243	.000*
3-Assessments	6.64	6.80	-4.049	244	.000*
4-Follow up	6.65	6.62	.827	244	.409
5-Prevent	6.59	6.41	4.112	239	.000*
6-Safety	6.74	6.74	-.064	243	.949
7-Consulting	6.65	6.59	1.281	243	.202
8-Timely	6.53	6.55	-.468	243	.640
9-Alert	6.74	6.31	12.605	242	.000*
10-Intuition	6.45	6.31	2.437	242	.016*
11-Normal	6.83	6.95	-3.426	244	.001*
12-Intervention	6.71	6.69	.606	244	.545
13-Patient	6.46	6.22	4.517	244	.000*
14-Low Tech	6.51	6.21	5.967	244	.000*
15- Wide Range	6.38	6.34	.710	244	.478
16- All Options	6.60	6.35	6.074	244	.000*
17- Natural	6.66	6.44	5.230	243	.000*
18- Personal	6.71	6.67	1.001	244	.318
19- Presence	6.66	6.38	7.035	243	.000*
20- Validation	6.74	6.61	3.492	244	.001*
21- Respect	6.79	6.75	1.039	244	.300
22- Family	6.74	6.80	-1.597	243	.112
23- Confidentiality	6.78	6.89	-2.915	244	.004*
24- Adapting	6.63	6.40	5.207	244	.000*
25- Wholistic	6.54	6.64	-2.094	243	.037*
26- Involving	6.61	6.27	8.105	243	.000*
27- Accessible	6.63	6.22	8.832	241	.000*
28- Time	6.64	6.12	11.679	241	.000*
29- Education	6.74	6.67	1.692	242	.092
30- Consent	6.65	6.29	6.826	241	.000*
31- Voice	6.59	6.73	-2.804	244	.005*
32- Partner	6.62	6.29	7.302	244	.000*
33- Helping	6.64	6.69	-1.225	243	.222
34- Advocating	6.71	6.57	3.645	244	. 000*
35- Gentle	6.79	6.42	10.269	244	.000*
36- Updating	6.66	6.73	-1.605	244	.110
37- Reflection	6.34	6.49	-2.403	240	.017*
38- Peer-review	6.38	6.04	5.616	241	.000*
39 -Balance	6.55	6.12	7.266	241	.000*

Note: XS stands for Means of Student's Ideal perception for this dimension. XD stands for the mean reported from the Delphi study for this dimension.

* refers to values that are significant

T value is calculated at .05 degree of significance.

The five Dimensions for the Ideal perception of exemplary midwifery process that were reflected in a significantly lower mean in the student sample than in the expert population is illustrated in table 4.13 as summary, where XS represents the mean emphasis of Respondents and XD the mean emphasis of Delphi experts.

Table 4.13

Comparison between the Means of Ideal from Delphi and Respondents, for Dimensions ranked lower by respondents

Dimension	XS	XD	Discussion
#3 Doing on-going Assessments	6.64	6.80	Assessments perceived as less reflective of exemplary midwifery by new graduates potentially because of lack of experience in the clinical field.
#11 Support the normal	6.83	6.95	Potentially Insecure in their new role. Still ranking the highest for new grads' perception
#23 –Confidentiality	6.78	6.89	New grads never had full responsibility as students for a caseload. They may perceive confidentiality as less important because of their need to discuss cases as part of the student role
#31 – Listening to the woman's voice	6.59	6.73	Again potentially due to lack of professional maturity
#37- Using reflection	6.34	6.49	Perhaps perception that only students use reflection, not full fledge certified professional

Table 4.14 uses the five thematic groupings introduced earlier in his chapter to compare the mean emphasis of experts midwives from the Delphi study with that of the respondents.

Table 4.14

Difference in the Means of Ideal Perception of Students Respondents and the Delphi Experts, by Groupings

Grouping	XS	XD	t	df	Sig (e-tailed)
Therapeutic	59.38	58.51	2.756	242	.006 .
-Support the Normal Process of Birth					
-Vigilance and attention To details	66.21	64.84	4.598	232	.000
Caring					
-Respect the Uniqueness Of the woman	60.11	65.73	-18.498	240	.000
-Respect the woman Through the setting	40.10	38.37	8.334	238	.000
Professional Issues	25.94	25.38	3.000	237	003

Note: XS stands for the mean of the grouping for the student respondents. XD stands for the mean of the grouping for the Delphi Experts.

The T-test was not significant for any of the groupings , and in four out of five groupings, the student's mean was greater than that of the Delphi Expert. Grouping : Caring: Respect the uniqueness of the woman, presenting with a mean slightly lower than that achieved by the Delphi experts also contains two of the dimensions that already were noted as lower than that of the Delphi experts, "Confidentiality" and "Listening to the woman's" voice . When compared as an aggregate, however, the mean was not significantly lower.

In summary, we can be confident that for 34 of the 39 dimensions of the Ideal perception of exemplary midwifery process, the graduating students shared with the Delphi Experts high emphasis on those dimensions that are reflective of exemplary midwifery . Perhaps the analysis of the "comments" offered by the respondents after each dimension will shed light on the five dimensions perceived by the respondents as less representative of exemplary midwifery. (Section 5)

Testing Null Hypothesis 2

There will be no difference between the espoused theory of Delphi Experts and the degree of emphasis of the observation on Actual exemplary midwifery process by graduating student during last clinical experience/integration on all 39 dimensions

This hypothesis is tested in the following manner: The mean for each dimension of the Actual observation of exemplary midwifery process is compared with the mean of each equivalent dimension isolated by the Delphi Experts as representative of exemplary midwifery process. A one sample t-test is used to find significance for the decision to accept or reject the null hypothesis

Table 4.15 represents the results of the t-test as it compares the significance between the means for emphasis of the Delphi experts (Ideal exemplary midwifery process) and the mean for Actual observed emphasis from the respondents for all 39 dimensions

For all other dimensions, the null hypothesis is rejected. Lack of congruence between Ideal perception of exemplary midwifery and Actual observation by respondents is further confirmed for 38 of the 39 dimensions which suggests that the Actual observation of exemplary midwifery by the respondents was not reflective of the exemplary midwifery process identified by the Delphi experts. Table 4.15 describes the results of the t-test for all of the 39 dimensions. an asterix identifies the dimension(s) with a difference that attains statistical significance.

Table 4.15

T-test comparing the mean of the Actual observation from respondents to the value assigned to same dimension by Delphi Experts

Dimension	XS actual	XD	t (2-tailed)	df	sig
1- Vigilance	5.75	6.41	-9.615	244	.000
2- Documenting	5.73	6.10	-5.161	244	.000
3- Assessments	5.79	6.80	-14.881	244	.000
4- Follow up	5.32	6.62	-14.012	243	.000
5- Prevent	5.36	6.41	-12.915	240	.000
6- Circle of Safety	5.95	6.74	-10.370	243	.000
7- Consulting	6.09	6.59	-7.511	242	.000
8- Being timely	5.76	6.55	-10.620	243	.000
9- Remaining alert	6.10	6.31	-3.570	243	.000
10- Using Intition	5.33	6.31	-11.310	244	.000
11- Support normal	5.45	6.95	-15.434	244	.000
12- Intervention	4.97	6.69	-17.258	244	.000
13- Patient	4.86	6.22	-15.112	244	.000
14- Low tech	4.81	6.21	-14.882	244	.000
15- Wide range	4.85	6.34	-16.683	244	.000
16- All options	5.27	6.35	-14.038	244	.000
17- Natural	5.25	6.44	-11.441	244	.000
18- Personalizes	5.30	6.67	-14.845	244	.000
19- Supportive Presence	5.05	6.38	-12.992	244	.000
20- Positive validation	6.02	6.61	-7.486	244	.000
21- Respect	6.06	6.75	-9.740	242	.000
22- Respect family	6.03	6.80	-10.804	244	.000
23- Confidentiality	5.90	6.89	-11.159	244	.000
24- Adapting	5.31	6.40	-12.260	244	.000
25- Wholistic	5.00	6.64	-18.774	242	.000
26- Involving family	5.63	6.27	-7.701	242	.000
27- Accessible	5. 63	6.22	-6.402	241	.000
28- Providing time	5.37	6.12	-8.778	241	.000
29- Education	5.56	6.67	-13.398	242	.000
30- Informed Consent	5.83	6.29	-4.757	241	.000
31- Voice of the woman	5.60	6.73	-13.812	244	.000
32- Partner	5.58	6.29	-8.426	244	.000
33- Helping inner strength	5.26	6.69	-16.133	243	.000
34- Advocating	5.66	6.57	-10.909	243	.000
35- Gentle	6.30	6.42	-1.887	244	.060*
36- Updating	5.54	6.73	-13.840	244	.000
37- Using Reflection	5.02	6.49	-15.387	239	.000
38- Peer-review	4.69	6.04	-11.955	241	.000
39- Balance	4 .32	6.12	-15.028	242	000

Note: XS stands for Means of Student's Actual Observation for this dimension. XD stands for the mean reported from the Delphi study for this dimension.
* refers to values that are significant
T value is calculated at .05 degree of significance.

Discussion: The results of the above t-test for Null Hypothesis II, that there will be no difference between Exemplary Midwifery dimensions defined by experts and the degree of emphasis of the observation of Actual exemplary midwifery process during integration, are displayed in table 4.15. The null hypothesis is rejected for all but for one dimension, "Being gentle" where it is accepted. , and congruence between the Ideal perception for exemplary midwifery and the Actual observation is granted .

Testing Null Hypothesis

There will be no difference between the Actual observed process of Exemplary Midwifery during Integration and the Ideal espoused midwifery theory of respondents , using thematic dimension groupings.

This hypothesis in fact predicts that there will be a high emphasis on the implementation of exemplary midwifery process as observed during integration, since the Ideal perception of the student will be matched by the high emphasis potentially observed during integration.

Table 4.16 identifies all five groupings and the results of a paired t-test where the means of Ideal perception of respondents and the means of Actual observation of exemplary midwifery process by the same respondents are compared.

Table 4.16

Paired T-Test Results Showing Significant Differences on Mean scores (for Actual and Ideal) Within Each Grouping

Factor	Actual	Ideal	t	df	p
Therapeutic					
Respect the Normal process	45.6488	59.3719	4.358	241	.000
Vigilance and attention	57.0693	66.2294	20.677	230	.000
Care					
Respect the Uniqueness	57.2500	60.0958	4.358	239	.000
Respect through the setting	34.0000	40.0966	17.879	237	.000
Professional Issues	19.5714	25.9370	21.809	237	.000

Note : All significance at the .05 level. T-Tests were two-tailed

The paired t-test showed significance at the .05 level, which means that the null hypothesis number 3, that there will be no difference between the Actual observed emphasis on exemplary midwifery process and the Ideal perception of the graduating students is rejected. There is a real difference in these two populations, and the emphasis of Actual observations by the students is different from the emphasis perceived as Ideal. The means for all Actual observations, for each grouping is significantly lower than the corresponding mean for the Ideal hence test also informs us as to the direction of the difference; clearly it emerges from this analysis that the observation of exemplary midwifery process by the respondents receives a much lower emphasis than the expected Ideal perception of exemplary midwifery process. If one defines congruence by the similarity of the two populations means, then we have low congruence between the Ideal perception of exemplary midwifery by the students, and their Actual observation of the exemplary midwifery in the clinical setting.

Testing Null Hypothesis 4

That there will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home Birth Practice, Birth Center, Level 1&2 Hospital, or level 3 Hospital .

Analysis of Variance (ANOVA) was used to compare the Means of each of the 5 groupings: "Vigilance and attention to details", "Support the normal process", "Respect the uniqueness of the woman", "Respect the woman through the setting", and "Professional issues" as they are Actually observed at each of the four clinical location. Table 4.17 describes the distribution of scores Means and Standard Deviation for each of the five groupings.

Table 4.17

Means and Standard Deviations for Four Clinical Settings and Five Dependent Variables

	Home Birth		Birth Center		Level 1&2		Level 3	
Variable	M	SD	M	SD	M	SD	M	SD
Support the normal process	45.57	11.21	52.32	10.55	45.87	9.23	47.73	10.48
Vigilance and attention to Details	49.28	12.96	58.72	7.82	57.84	7.26	56.49	7.44
Respect of the woman as Unique	64.42	31.05	59.56	9.82	57.35	9.22	56.05	11.42
Respect of the woman through the setting	31.67	8.87	36.50	6.61	33.95	5.35	33.61	6.32
Professional Issues	16.43	5.56	19.08	4.56	19.49	4.45	19.99	5.24

Table 4.18 offers the result of the ANOVA test for each of the five groupings, when compared with the four locations of clinical settings: Birth Center, Home Birth practice, Level 1&2 hospital and Level 3 hospital.

Group: Therapeutic: Support the normal process of birth

ANOVA test with the mean for the grouping: Therapeutic : Support the normal process of birth with all four clinical settings, Home birth practice, Birthing center, Level 1 and 2 hospital, and Level 3 hospital resulted in a significant F ratio. This means that the null Hypothesis is rejected for this grouping because there is a significant difference between the mean of this grouping when compared to each of the clinical setting. The analysis of the Tukey HSD allows us to identify Birth Center with a mean of 52.32 was significantly higher than the mean of 45.87 for Level 1&2 hospital and 47.73 Level 3 hospital. This means that this grouping of "Support the normal process" was observed with a mean significantly higher in a Birth center setting

Group : Therapeutic: Vigilance and attention to details. :

The result of this ANOVA is also significant. When the mean of this grouping: "vigilance and attention to details" is compared within all four settings, we find a significant difference, which means that the null hypothesis is again rejected for this group. "Vigilance and attention to details" is not receiving the same emphasis within the four clinical settings.

Tukey HSD helps us identify Home Birth practice as the setting most likely to differ when compared with Level 1&2 hospital and Birth Center. The mean for This grouping in the Home birth is 49.28, which is significantly lower than the mean of 57.84 in the Level 172 hospital setting, for the same grouping. No significance was identified by the

Tukey post hoc test when Home Birth practice's mean was compared with the mean for Level 3 hospital, 56.49.

The means of the three other groupings, "Respect the uniqueness of the woman", "Respect the woman through the setting", and "Professional Issues" were not significantly different in all four clinical settings.

Table 4. 18

One-Way Analyses of Variances for Effect of Location of Clinical Setting on Five Groupings of Dimensions

Variable and source	df	ss	ms	F
Respect the normal process				
Between groups	3	1459.73	486.58	4.95**
Within groups	239	23494.5	98.30	
Vigilance and attention to details				
Between groups	3	587.53	195.84	3.40**
Within groups	232	13350.3	57.55	
Respect the Uniqueness of the Woman				
Between groups	3	624.73	208.24	1.66
Within groups	237	29773.4	125.63	
Respect the woman through the setting				
Between groups	3	196.99	65.66	1.85
Within groups	235	8356.94	35.56	
Professional Issues				
Between groups	3	91.09	30.37	1.31
Within groups	235	23.05		

*p< .05. **p,< .01. ***p < .001 .

Discussion

Hypothesis number 4 , that there will be no association between the extent of implementation of exemplary midwifery practice and type of clinical setting, such as Home Birth Practice, Birth Center, Level 1&2 hospital, or Level 3 hospital has been partially rejected, and partially accepted. The hypothesis has been rejected for the grouping: " Support the normal process of birth", and grouping; : "Vigilance and attention to details". Birth center location has been singled out as significantly different for the first grouping, and Home Birth for the second grouping.

The null hypothesis has not been rejected for the other three groupings : "Respect the uniqueness of the woman", "Respect the woman through the setting", and "Professional issues", meaning that in all four clinical settings, those grouping were implemented with comparable emphasis.

Testing Null Hypothesis 5

That there will be no observational difference between the respondents' observation of exemplary midwifery process and types of educational programs, i.e. Certificate, Masters, BA to BSN to CNM, or AD to BSN to CNM. Only one candidate among the respondents attended a AD to BSN to CNM program, so the data was eliminated from the statistical program (SSPS 7.5) .

Table 4.19 describes the mean and standard deviation for each of the three types of educational programs.

Table 4.19

Means and Standard Deviations for three types of Educational Programs and Five Dependent Variables

	Masters		Certificate		BA to BSN to CNM	
Variable	M	SD	M	SD	M	SD
Support the normal process	42.21	9.35	42.27	11.36	41.88	12.12
Vigilance and attention to Details	57.29	7.22	58.22	7.71	50.87	9.78
Respect of the woman as Unique	57.71	10.48	57.62	12.88	51.47	10.95
Respect of the woman through the setting	34.15	5.39	34.55	6.43	30.29	8.33
Professional Issues	19.94	4.62	19.12	5.22	17.00	4.81

Table 4.20 reports on the five ANOVA tests that were conducted on each of the five groupings when compared with the three educational programs .

There is a significant difference in the means of three of the five groupings. "Vigilance", "Respect through the setting" and "Professional Issues" .

Grouping:Vigilance and Attention to Details:

Comparison of means for the grouping "Therapeutic: Vigilance and attention to details" is significant at the .05 level, hence the hull hypothesis is rejected for this grouping. There is a significant difference between the groups and Tukey HSD helps us identify the program BA to BSN to CNM ,as differing significantly from both Masters and Certificate types of programs. The mean of 50.87 for the observed emphasis on this grouping in the BA to BSN to CNM programs, was significantly lower than the other types of programs, Maters, (mean 57.29) and Certificate (58.22) .

Table 4.20

One-Way Analyses of Variances for Effect of Types of Educational Programs on Five Groupings of Dimensions

Variable and source	df	ss	ms	F
Respect the normal process				
Between groups	2	300.36	150.18	1.47
Within groups	239	24476.5	102.41	
Vigilance and attention to details				
Between groups	2	667.45	333.72	5.88**
Within groups	232	13152.7	56.69	
Respect the Uniqueness of the Woman				
Between groups	2	611.564	305.78	2.44
Within groups	237	29671.4	125.19	
Respect the woman through the setting				
Between groups	2	256.49	128.25	3.66*
Within groups	235	8356.94	35.56	
Professional Issues				
Between groups	2	145.83	72.92	3.21*
Within groups	235	5341.56	22.73	

*p< .05. **p,< .01_ ***p < .001 .

Group: Caring: "Respect the woman through the Setting".

The hypothesis is rejected at the .05 level for this grouping. A post hoc Tukey HSD test reveals that the mean of the type of program BA to BSN to CNM was significantly lower, at 30.29 than the two other types of programs, Masters (mean: 34.15) and Certificate.(mean :34.55)

Grouping: "Professional Issues"

The null hypothesis is also rejected for this grouping, focused on the Professional issue dimensions . A look at the Tukey HSD also informs us that again , the type of program BA to BSN to CNM 's mean of Actual observation was significantly lower (17.00) from the Masters program (mean: 19.94), but not significantly lower than the Certificate program.(mean 19.12)

The other two groupings, " Respect the uniqueness of the woman" and "Respect the normal process of birth" were not significantly different among all three educational programs.

Discussion

The program BA to BSN to CNM was identified as differing significantly in three of the five groupings for the Actual observation of exemplary midwifery process. The number of respondents from these types of programs, numbering 17, or 7% of all respondents, compared with the Masters programs, at 163, (67%) and Certificate programs , 64 (26 %) is significantly smaller . This difference in number might account for the difference in results. It would also be interesting, for further studies, to compare the Ideal perception of exemplary midwifery espoused by those respondents who entered midwifery after obtaining a degree in a different field. It could be hypothesized that the difference in their espoused theory colored the intensity of their observation of emphasis of Actual process.

Testing Null Hypothesis 6

That there will be no difference between the observed emphasis on exemplary midwifery process by respondents from Traditional Programs, (on site) versus Distance-Learning programs (web-based or others)

An Independent sample T-Test was used:

Table 4.21 offers a description of the result of an Independent sample t-test between the mean for Actual emphasis for Traditional programs compared with Distance learning programs.

The results of this t-test for comparison of means between each of the five groupings and the Distance vs Traditional programs were not significant. The null Hypothesis 5 was then not rejected, and the values of the Actual observation of exemplary midwifery process can be expected not to vary significantly depending on this type of midwifery education.

Table 4.21

Difference in the Means of the Actual Observation of Exemplary Midwifery Process of students from Distance Learning and Traditional Programs.

Grouping	XD	XT	t	df	Sig(2-tailed)
1- Therapeutic					
- Support the Normal Process of Birth	45.9600	45.5952	-.258	241	.797
- Vigilance and Attention To details	57.5467	57.0000	-.507	234	.613
2- Caring:					
- Respect the Uniqueness Of the Woman	57.8082	57.0714	-.466	239	.641
- Respect the Woman Through the setting	34.2432	33.9152	-.390	237	.697
3- Professional Issues	19.2361	19.6707	.640	237	.523

Note: XD stands for the Mean distance Learning programs. XT stands for the mean of Traditional Programs. Significance is at the .05 level

Table 4.22 offers a summary of all six null hypotheses and their result. Hypotheses number 3 and 6 were rejected, and the other 4 partially rejected and partially accepted.

Table 4.22

Summary of the Statistical analysis:

Hypotheses	Results
1.There will be no difference between the respondents ' espoused that of Delphi Experts on all 39 Dimensions.	Partially rejected/Partially accepted Rejected for 27 dimensions, however grads' mean higher than experts in 22 dimensions
2.There will be no difference between the espoused theory of Delphi Experts on all 39 dimensions and the degree of emphasis on the observation on Actual exemplary midwifery process by graduating student during last clinical experience/integration	Partially rejected/Partially accepted Rejected for 38 dimensions. Only "Being gentle" was not rejected
3.There will be no difference between the Actual observed process of Delphi Experts during Integration and the Ideal espoused midwifery theory of Respondents , using thematic dimension groupings	Rejected for all five groupings
4.There will be no association between the extent of implementation of exemplary midwifery practice and type Of clinical setting, such as Home birth Practice, Birth Center, Level 1&2 Hospital, or level 3 Hospital	Partially rejected/Partially accepted Rejected for Normal process, Vigilance Accepted for Respect, Setting and Professional Issues
5. That there will be no observational difference between respondent's observation of exemplary midwifery process and types of educational programs, i.e. Certificate, Masters , BAto BSN to CNM, or AD to BSN To CNM	Partially rejected/Partially accepted rejected for "vigilance" "Respect through the setting"and "Professional Issues" Accepted for 'Respect the uniqueness and "Support the Normal"
6. That there will be no difference between the observed emphasis on exemplary midwifery process by respondents from	Not rejected for all five groupings

Qualitative Analysis

Section 5, the last section of Chapter 4, presents the content analysis of qualitative data collected from three sources on the questionnaire. The three sources include: (1) respondents' comments which were written in on the lines provided after each of the 39 survey questions; (2) unique vignettes submitted by the respondents in answer to the question, "Was there a unique experience that you had that reflected exemplary midwifery practice, or one that did not reflect exemplary midwifery practice?"; and (3) responses to a checklist added at the end of the survey preceded by the question, "If you found that your clinical experience did not match what should have occurred, please indicate what factors might have contributed". The final checklist of factors was developed from written-in responses to the researcher's pilot study for the survey questionnaire. The questionnaire developed for this study provided the respondents with three additional opportunities to comment on their experiences during their final clinical experiences/integration. Data collected from these three areas was qualitative and represented personal reflections in addition to their selections on the 7-point twin scale of the Ideal/Actual survey on exemplary midwifery processes/practices. While the scaled items represented the degree of emphasis the respondent gave to both Ideal and Actual items, the qualitative data represented the respondent's personal reflections only on their observations. Any additional written comparisons made by the respondents between their ideal expectations of exemplary midwifery practice and their self-reported observations can not be directly correlated with the results of the statistical analysis.

Section 3 presents an overview of the descriptive categories extracted through content analysis of the respondents' additional comments and the vignettes offered as examples of "final unique experiences". First, the results from the question added in Part II of the survey questionnaire: "If you found that your clinical experience did not match what should have occurred, please indicate what factors might have contributed" are offered . Next a content analysis is presented organized as follows: first, a brief report on the frequency and overall distribution of descriptive comments, then a table of the qualitative classification of those comments (Table 4.23). Written responses were read and re-read several times and then systematically content analyzed, line by line. Qualitative classifications were developed to reflect positive descriptive comments (i.e. positive descriptors/+); negative descriptive comments (i.e. negative descriptors/-); and neutral descriptive comments (i.e. comments with both positive and negative descriptive comments or qualifying comments +/-). Table 4.24 represents, by frequency, the most frequent recurring positive (+), negative (-), and neutral (+/-) descriptors. This will be followed by a summative narrative explicating the recurring positive, negative and neutral descriptive statements and/or examples. These positive, negative, and neutral descriptive categories represent the respondents' reflections and/or personal assessments triggered by the purpose of the study and the content of the 39 dimensions on exemplary midwifery processes/practices.

This qualitative data was systematically analyzed, categorized (+, -, +/-), and presented as a frequency table. The positive, negative, and neutral descriptive categories extracted through content analysis reflect situational factors identified by the respondents as supportive for exemplary midwifery processes/practices; situational factors that were

described as non-supportive for exemplary midwifery processes/practices; or situational factors that prompted the respondent to report qualifying statements that included both positive and negative descriptors. Situational factors were identified by the researcher for the descriptive categories.

Situational factors extracted through qualitative content analysis were then examined within the context of the results and responses reported through the survey. Preliminary inferences are made with respect to possible situational factors that might explain why incongruencies were found in the study between the espoused theory and the actual observations of clinical educator practices as reported and described by newly graduated midwives. Finally, a detailed account of the comments for each of the 39 questions is offered.

Content Analysis of Written-in Respondent Comments

A total of 198 (80%) of the respondents added at least one comment to the survey questionnaire. The range of comments to the survey questions were from
4 comments to Question 32, "Working as a partner with the woman" to
41 comments to Question 12, " Intervening only when necessary and appropriate". Sixty one respondents added a "Unique event" at the end of the survey. Content analysis was conducted as follows. The researcher conducted a comprehensive first reading of all respondent comments to each of the 39 dimensions of nurse-midwifery processes/practices questions. All quoted comments were entered into a Word file and given a code by the number of the questionnaire; how many preceptors were identified; the type of educational program (M=MSN; C=Certificate; BA= BSN); whether the

program was Traditional (T) or Distance (D); and the place of midwifery clinical practice/integration site (Level 1 hospital =1; Level 2 hospital =2; Level 3 hospital =3; Birth Center = BC; Home Birth = HB) For example, using a comment made on Question 1 of the survey about Being vigilant and paying attention to details, one respondent wrote, "Always made sure the atmosphere was pleasant dimmed lights, soft noise, etc." was labeled as:

(89-3MT2) Survey #89, 3 preceptors identified, MSN educational program, Traditional, Level 2 Practice Site. Each of the respondent comments were coded in this manner when entered into the Word file.

A second reading of all the comments was then conducted and a pattern of responses was identified. Responses fell into three developed categories; Positive Descriptive Statement. For shorthand purposes, a plus sign (+), negative sign (-), and a plus/minus sign (+/-) represented the three identified categories and was placed in front of each respondent comment. On third reading, respondent comments fell into one of the three identified categories and a +, -, or +/- was placed in front of each comment. For example, using Question 1, "Being vigilant and paying attention to details."

1. Positive Descriptive Statement (+). Positive comments which reflected both positive experiences and/or examples as well as specific positive responses to the exemplary dimension identified by the question.

+ (89-3MT2) "Always made sure the atmosphere was pleasant dimmed lights, soft noise, etc." , reflected a positive descriptive statement made by the respondent on Survey questionnaire #89 who had her experiences with 3 preceptors, had graduated from a Master's in Nursing/Midwifery program using

the traditional model of education, and who had her final clinical experiences/integration at a Level 2 hospital.

2. Negative Descriptive Statement (-). Negative comments which reflected both negative experiences and/or examples as well as specific negative responses to the exemplary dimension identified by the question.

- (21-6cd3) "Too little time and caregiver communication never reach client, in hospital, RN still has the most contact with laboring patient". reflected a negative descriptive statement made by a respondent on Survey questionnaire #21 who had her experiences with 6 preceptors, had graduated from a certificate program using the distance education model, and who had her final clinical experiences/integration at a Level 3 hospital.

3. Neutral or Qualifying Descriptive Statement (+/-). Comments made by respondents that either contained both positive and negative descriptive comments or qualified their responses based on a situational description.

+/- (62-6MT3) "Preceptors in delivery were much more vigilant than preceptors in clinic." reflected both a positive comment and a negative comment in the same statement made by a respondent on Survey questionnaire #62 who had her experiences with 6 preceptors, had graduated from a MSN/Midwifery program using the Traditional model of education, and whose final clinical experiences/integration occurred in a Level 3 hospital. This response was given the code +/- because it identified both positive and negative comments based on the situational context of where midwifery care was being given by preceptors and observed by the respondent

+/- (125-17CD2) "Varies tremendously among midwives." reflected a statement made by a respondent on Survey questionnaire #125 who had her experiences with 17 preceptors, had graduated from a Certificate Program using the Distance model of education, and whose final clinical experiences/integration occurred at a Level 2 hospital. This response was coded +/- and identified as neutral in that the respondent did not give specific details reflecting positive or negative impressions.

Some of the respondents comments did not fit well into any of the three identified categorical classifications of Positive Descriptors, Negative Descriptors, or Neutral or Qualifying Descriptors. These comments were given an Unclear for Adequate Interpretation code (~), and for coding purposes collapsed into the Neutral or Qualifying Descriptor Category. An example of this from Question 1 follows:

~ (147-4MT2) "new graduate [happy face]". This comment reflected the response given on Survey questionnaire #147 who had her experiences with four preceptors, graduated from a traditional Masters Degree in Midwifery program and had her final clinical experiences/integration at a Level 2 hospital. This comment did not directly address Question 1 and was interpreted to mean that the respondent was describing herself as being too new to meet the exemplary practice of always being vigilant and attentive to details. Since the response did not fit well into the identified categories, it was coded as unclear for adequate interpretation (~).

After a fourth reading of all of the coded comments and identified categories, it was noted that the comments coded as Unclear for Adequate Interpretation reflected a small

number of responses. For frequency of category response analysis the descriptive comment category of Unclear for Adequate Interpretation (~) was collapsed into the Neutral or Qualifying Descriptive Category.

A fifth interpretive reading was conducted. Each of the respondent comments was compared by the Descriptive Category Coding against the emphasis the respondent gave to the survey question on the Observed Scale. Inferences were made that when a respondent's qualitative comment was a positive descriptive statement and the respondent gave high emphasis to the question (6 and 7) on the Observed Scale that this could be interpreted to mean the qualitative response supported the Actual Observation.

This interpretation was conducted for each particular dimension. Comments were examined for their tendency to add a "supportive" ,"non supportive" ,or "neutral" explanation to the Actual observation of emphasis of exemplary midwifery process. For example, a respondent that commented " My integration preceptor was big on attention to details" strongly supported Actual observation of high emphasis on Question 1, " Vigilance and attention to details". Another respondent commenting: "As a student I found many clinical errors , omissions, etc" was not supportive of a high emphasis on the actual observation of exemplary process for Question 1, "Vigilance and attention to details" . Neutral comments were simply adding information , such as the following example to Question 1: "Varies tremendously among midwives" Table 4.23 represents the frequency in % of supportive, non-supportive or neutral comments for each dimension.

Table 4.23

Questions	N	% Neutral (+/-)	%- Descriptors	% + Descriptors
1. Vigilance	15	40	27	34
2. Documenting	17	0	65	35
3. Thorough	9	0	89	11
4. Follow up	17	12	88	0
5. Prevention	17	0	71	29
6. Circle of Safety	19	11	58	32
7. Consult/Refer	20	0	60	40
8. Timely	12	8	75	17
9. Alert to Changes	8	50	25	25
10. Intuition	22	23	55	23
11. Support Normal	27	11	85	4
12. Intervene prn	41	7	93	0
13. Patience	26	7	85	8
14. Low tech	25	12	84	4
15. Resources used	21	10	67	23
16. All options	8	0	75	25
17. Natural uses	14	0	79	21
18. Personalizing	16	19	69	13
19. Presence	26	19	69	12
20. Encouragement	7	0	57	43
21. Respectful	12	8	67	25
22. Family as supp.	11	0	64	36
23. Confidentiality	7	0	57	43
24.Cultural needs	21	29	48	24
25. Wholistic	9	22	78	0
26. Family involve.	11	9	64	27
27. Accessible	11	9	82	9
28. Adequate time	21	10	76	14
29. Education/Info	13	23	54	23
30. Consent	17	6	47	47
31. Women's voice	8	12	75	13
32. Partner	4	25	75	0
33. Wom.Inner Stre	9	0	78	22
34.Advocating	8	0	50	50
35. Gentle	7	14	28	57
36. Prof.knowledge	17	29	53	18
37. Reflection	12	8	42	50
38. Peer Review	10	20	60	20
39. Balance	25	12	76	12
Unique experience	61	16	30	54

Most Frequent Responses by Checklist Data

The respondents were given a third qualitative opportunity for a final reflection on exemplary midwifery practice at the end of Part 2 of the survey. This checklist of situational factors was developed from comments made by respondents to the Pilot Study conducted on the development of the survey questionnaire. In the event that the respondent was rushed for time or had other circumstances that prevented them from writing in comments, a checklist of situational factors was provided. These situational factors were extracted from responses made by a cohort group of newly graduated midwives that identified reasons the cohort group believed were responsible for why their actual observations did not match with their ideal expectations on midwifery processes reflecting exemplary midwifery practices. The checklist of situational factors offered the larger cohort of midwifery respondents the opportunity to concur or disagree with the cohort's experiences.

Following are the results from the checklist responses to the final section of the survey in answer to the question, "If you found that your clinical experience did not match what should have occurred, please indicate what factors might have contributed"

Of a total of 245 respondents , 200 checked at least one of the possible four answers:

Lack of follow up	49 (25%)
Not enough time	52 (26%)
Interference in hospital settings	61 (30%)
Lack of private time	115 (58%) (balance between professional/private time)

A sixth reading was then conducted of the comments added by the respondents on each of the Survey questions. As noted in Table 4.23 the preponderance of Descriptive Statements were categorized as Negative Descriptive Comments and further interpreted to reflect as not supportive of a high emphasis on the actual observation of exemplary process.

Table 4.24 identifies the most frequently encountered situational factor extracted from the comments added by the respondents after each of the 39 dimensions.

Table 4.24

Situational Factors	# of occurrences
Practice location	134
Environmental support/lack of support	129
Type of practice (solo, group),	114
Client volume and time available	103
Liability concerns	98
Amount of support from collaborating physicians	90
Midwifery client personality	65
Internal midwifery group dynamics	50

Comments from the Respondent's Unique Experience Vignettes

Sixty one (25%) of the total number of respondents added a final comment or clinical vignette, described as a unique experience. While survey responses and comments were overwhelmingly negative in observation – where most of the characteristics of exemplary midwifery were not observed - in this section, respondents had more positive stories and comments about their experiences. Situational constraints to practicing espoused theory were identified and closely matched responses made as comments and responses to the checklist. Environment of practice, culture of practice (medical, midwifery, or ancillary services), institutional inflexibility of protocols, women's own desires, individual midwive's variations in practice, lack of balance in professional lives, and fear of liability were dominant. However, the respondents felt that midwives as a group - tried - within these constraints to practice espoused theory.

Reviewing the comments and final "Unique experience" identifies Practice location as the single most significant inhibitor for the implementation of exemplary midwifery process. For example, looking at Question 1, "Vigilance and attention to details", comments such as : "Have no one else to rely on" from a midwife practicing in a Home birth to " almost non existent" when referring to Question 2 "following up on care". The last comment was offered by a midwife practicing in a Level 3 hospital.

Supporting the normalcy of birth, one of the hallmarks of midwifery practice (Appendix D) was reported as not facilitated or supported in actual practice by 23 of the 27 respondents. Respondents felt strongly that it was not possible to support the normalcy of birth because of situational factors: specifically, institutional constraints, medicalization of birth, the inflexibility of institutional policies and protocols when

working under medical supervision , fear of litigation, ritualized practice, and the culture of medicine that views pregnant and laboring woman as "at risk" to some degree. Pathology of reproduction dominates the literature, the protocols, and the practices in obstetrics. Women are viewed in the framework of potential for pathology or in the sick role, requiring medical vigilance, supervision, and/or intervention. In the medicalization of reproduction, women are categorized as minimally at risk, moderately at risk, significantly at risk, or seriously at risk. Normalcy and no risk is collapsed, my medicine, into the category of minimally at risk. According to the respondents, there was a very high experience of intervention, most of them unnecessary and even dangerous. " It was all business-get the baby out- she is here to have a baby, so lets do it ASAP" (MD2). Not only physicians, but also midwives were practicing " convenience management and intervention"(MT3). One must remember that these observations of clinical management were recorded by new, very inexperienced practitioners who might not have been completely aware of the necessity and safety of the interventions.

Dimensions such as " Drawing on wide resources" "Using many options", "Using low technological wholistic approaches" were reported as non existent for most patients in most locations. " the more toys the hospital has and the more suit-happy the patients – the more technology can be overkill"(CT3). Also, one comment that was not matched by other similar ones but could reflect a change in focus and emphasis, " Our client population often expected and desired interventions , especially epidurals"

Tailoring the care to the woman's desires was difficult, again due to hospital settings where individualization was not promoted. Constraints were again identified as

place of practice, type of practice, protocols, status quo of medical culture or midwifery culture. One-fit-all approach was the general theme.

Supportive presence in labor, the hallmarks of midwifery care (Appendix D) was very poorly represented ,not only with a low emphasis on the Actual observation but also as evidenced by the high frequency in the number of non-supportive comments reported. Eighteen of the 26 respondents offered comments that did not support the observation of high emphasis of this dimension in practice. Volume of patients, was the most frequent reason given. One comment, although supportive of the dimension , challenged its supremacy as follows: " The midwife's role is one that encourages and enriches the couple working together (empower them)... the midwife is present when needed , but [I] do not believe in sitting the entire labor" (MT2)

Professional Issues , although receiving very low emphasis on Actual observation, reflected a surprising balance of supportive comments. The question " Updating knowledge" was clarified by the observation that midwives attempted to do this through home study, journal reading, on-site educational presentations, constraints were time, census, and finances.

Peer –review was not observed often perhaps because it was done apart from the student's clinical teaching time. Having a balanced life was unanimously ranked last, had the least congruence, and elicited comments that were non supportive in 19 out of 25 comments (76%) . Respondents stated that midwives sacrificed personal, and family needs to practice midwifery. It was not a behavior they were planning to imitate.

Graphic Depiction of Types of Responses

Broad Analysis, Question by Question

Respondents 's identifier: In parentheses, first letter: type of educational program

Masters :	M
Certificate:	C
BA to BSN to CNM:	BA

Second letter: Distance vs Traditional

Distance :	D
Traditional :	T

Third letter/number: Clinical setting

Home birth	HB
Birth center	BC
Level 1&2	2
Level 3	3

Q1	Vigilence	Varied with location of practice, practitioner, time available and liability. Solo practitioners "have no one else to rely on" there MUST be vigilant versus responses from "big on detail" to "many errors and omissions" Outliers - One felt vigilance > in prenatal practice; another felt vigilance > labor/birth For reflection – "…we actually have to watch all the subtle s/s more than we are taught" (MD3)
Q2	Documentation	Varied as above but also included comments about the value or lack of value of "template tools" While documentation was considered "ideal" – in reality practice does not support thorough documentation – and more than 50% felt it was not done very well. Forms may help improve thoroughness but may also detract from personalized care – ie going down a check list which "does not fit all women" Amount of type of documentation linked to liability concerns.
Q3	Thorough/Ongoing	Variability was fairly consistent for all questions –

		varied by location of practice,type of practice,etc
		Responses focused more on labor assessments and felt that ongoing assessments were done but thoroughness was inconsistent.
		Subtleties also lost in graphs and protocols – Excess attention to following Friedmans and protocols Without adequate rationale – resulting in too frequent exams etc. True observation for subtle Changes impossible to do in litiginous and protocol driven environments.
		Concern was voiced re: lack of diet, exercise, nutritional , and emotional health thoroughness – often absent.
		Outlier - Thoroughness has to be in context of culture. Example given – Amish women would be Less likely to accept questions re: sexuality, abuse, contraception . (MDHB)
Q4	Follow up care	Almost non-existant outside solo practices or birth center practices.
		Fragmented care without continuity was dominant answer. This was true for prenatal, birth, and Postpartum care – PP and breast feeding FU were particularly mentioned as inadequate to the needs of women
		Outliers – One respondent felt this was an administrative concern and "should not fall on the CNM" (MT2)
		Sometimes FU calls were made by practices but volume and busy practices led to exhaustion and impeded real FU care
Q5	Prevention of Prob	Similar constraints as above – time, high census, location of practice etc.
		Education in programs and for women was lacking in wellness and health focus. Without real continuity it was considered difficult, if not impossible, to establish

		a relationship that would support preventative care. Lack of nutrition guidance highlighted again. Reflective comment – "Need more CNM meetings/brainstorm…on how to improve/streamline services for everyone's benefit…there was an inertia to maintaining status quo." (MT2) Another commented…reactive rather than proactive "…good at solving problems when they occurred…" (MT2)
Q6	Circle of safety	4 respondents were unfamiliar with or unclear as to the meaning of "circle of safety" 11 described significant practices that were considered unsafe – ex. Active aggressive mgmt of third stage resulting in PPH – sadly this example occurred several times "often outside the realm of midwifery" (MDHB) "hospitals not safe place for low risk women [listing of interventions]" (CD3) "pulling on cord resulting in cord avulsion and hemorrhage" (MDBC) "high risk Level III hospital – no such thing as low risk patients" (MT3) " (midwifery) AROM before engagement of head" (MDBC) "…would slip outside the circle of safety in the same manner every time…"(CD2) Reflective comment – internal dynamics of practice may interfere with safety of families ex. "…too much dissention and politics [within midwifery group] to offer consistent, secure care." Student education issues and conflicts were also noted: ex. "…integration site must be 100% committed to allowing for the normal learning curve and consequential errors while not jeopardizing patient safety (or reputation of practice)" "…preceptor's circle of safety much larger than my own. I sometimes felt that staying within MY circle of safety was not emphasized or

		addressed…" (MT2)
		"…emphasis to gain experience…" led to student conflicts re: interventions for the sake of experience (MTBC)
		"…increased risk patients were taken on…often putting us in predicaments…"
Q7	Consultation	"…in 4 months did not witness (either)…" (MDHB)
		"theory did not match practice. Hard to be expert at normal when normal frequently becomes abn" (MD3)
		"…not that important except for surviving integration…" (BA T2)
		"…many forced to "inform" MDs when they did not actually need to…" (BA,T3)
		Seeking "…healthcare outside the circle of doctors and midwives was considered a weakness…" (MDHB)
		"..too much CYA (cover your ass) and not enough team work…" (CT3)
		"did not refer appropriately per ACNM guidelines but care excellent…had a strong faith and trust in the process." (BA, DHB)
		Conflicts when "…MDs wanted [midwives] to see everything…" (MT2)
		As students "…were expected to deal with high risk patients than should as students…"(MD3)
		Some sites may not have access to appropriate consultation ex "rural practices" and availability of adequate and/or appropriate mental health services. (MT2)
Q8	Timely actions	9 of 12 respondents felt that actions were less than timely – reasons given
		too quick because "MDs would otherwise take over…" (CT2)
		"either too active in management or not enough" lack of consistency (MT2)

		"unfortunately that's just the way of the world" ????(CD3) "…sometimes [as student] they let me wait too long…" at the expense of the woman (MT2) "hesitancy to act…almost like midwife wanted to believe the clinical picture was still normal when it really wasn't." (MT2) Reflective comment - "vague concept" in what sense and under what circumstances should one be tiely(MT3) . "only some actions need timeliness: which do and which do not needs clarification…"(MT2)
Q9	Alert to changing Clinical picture	volume and time set up constraints to attend to this with consistency Not always present over time to be able to observe changes Need to rely on "nurses" often to do this
Q10	Listening to One's own intuition	Variations as noted in first few questions – location, provider, practice type, threat of litigation "…never mentioned in education…" (MD3) "…so beaten so far into background by protocols and constant threat of legal action…" (MT2) "…no verbalization of this in hospitals…" (MT2) "…seemed aware of intuitive insights but were forced to follow protocols…" "No one ever said, Listen to your intuition." (CD2) Outliers: "…preceptor changed pattern for no one…" (MTHB) "intuition isn't a basis, just a warning" ???? "intuition should be based on research outcomes but can also be based on experience" (CD3)
Q 11	Supporting Normal	23 of 27 respondents felt strongly that this was not possible due to institutional constraints medicalization of birth, protocols, litigation, rituals, physicians overruling midwives, Women seen as "sick role" High experience of interventions

ENVIRONMENT DICTATED PRACTICE
NOT ESPOUSED THEORY

Q12 Intervening When necessary

Parallels above - also most respondents identified that AROM was frequently done by midwives

38 of 41 respondents described interventions when not needed
"AROMS were done routinely..." (MD3)
"had to intervene to keep labor progressing all the time" (MT2)
"too much pressure to intervene" (Masters, Distance, Level 3)
"done all the time to "get it over with" by midwife" (MT2)
"AROM to speed up labor so we can eat lunch" (MD2)

"it was all business – get the baby out – she's here to have a baby so lets do it ASAP." (CT3)
"[some midwife] known as "the hooker" another as "the stripper"..." (CD2

Varied with type of patient – "high intervention with practice patients [not private patients]"
"[midwife comment] keep the ball rolling"(MT2)
"AROM [seems to be] adopted as part of midwifery practice...midwifery inductions..."

Midwives equally demonstrating "convenience management"
Personal needs, exhaustion, high volume, call schedules

Reflective comment - "other factors should play in decision making besides physiological progress....psychological {progress equally important]" (CD3)

Outliers - Several commented that women are choosing interventions and if 'listening to Women" Is part of practice – then their choice needs to be supported

Q13	Patience	22 of the 26 respondents felt that the opposite was true – speed emphasized "environment dictates speed" (MD2) "clinic was how quickly we could get through the # of patients" (MT2) "schedule simply too busy" lack of time and busy services were most frequent reason for abandoning the luxury of patience Reflective comment – "unfortuneately practitioners have lives too. It's not always easy to be Patient (CD3)
Q14	Low tech	21 of 26 respondents felt that low tech was not part of practice – some constraints as mentioned Volume, site location, provider support, litigation, protocols, staff support etc Few has any opportunity to observe use of fetoscope, ambulation, hydrotherapy, position changes, use of alternative modalities "hardly a choice – unless patient begs" (MT2) "the more toys the hospital has and the more suit happy the patients – the more technology can be overkill" (CT3) Reflective comment - Clients desire interventions – part of sociocultural expectations of birth Management and experience (MT2) "our client population often expected and desired interventions, especially epidurals"
Q15	Drawing on Resources Tailoring care	Constraints as already noted above – place of practice, type of practice, protocols, status quo of medical culture or midwifery culture "…most found something that worked then stuck with it – did not branch out to tailor fit the patient." (MT2) In some locations – resources were at minimum

		Costs to hospital are also a consideration re: available resources (MT2) Low income families have constraints accessing resources
Q16	Options	Limitations noted - protocols, collaborating physicians desires, status quo "do it my way ASAP so we are not up all night" (CT3) "they each had a bias as to what they thought would work best and tried that first most of the time" (MT2) "they considered all their options but their options were epidurals yes or no" (MT2)
Q17	Natural Resources Ambulation	"hardly possible – not enough RNs" "they just didn't do it" (CT3) "our population requested other than natural resources" (MT2) Constraints as already noted – too many patients, too little time, protocols requiring set methods
Q18	Personalizing Care	11 of 16 respondents felt that protocols prevented personalizing care "one fit all approach" (CT3) "identical care from woman to woman" "protocols set the approach" (CD3)
Q19	Supportive presence	18 of 26 respondents did not observe this in practice. Volume of patients was the most frequent reason given - in fact 13 said #s of patients prevented this Reliance on nurses to provide support was identified by a few and one respondent felt that for The midwife to be the supportive presence "usurped the role of the nurse." "It was cruise room to room to AROM, pit, drug them – then back to deliver…" (CT3)

		"hard to do when you are the only CNM on a busy L&D" "midwife admitted then left" (MT2) "stays in office during days" (MD2)
		Reflective comment – "...the midwife's role as one that encourages and enriches the couple working together [empowering them]...[midwife] present when needed but do not believe in sitting the entire labor..." (MT2)
Q20	Positive Encouragement & Validation	One of the few questions with a balanced response - 3 observed supportive behavior; 4 observed inconsistent support "when present but not consistently"(BAT3) "hard to validate a woman who you yourself hooked up and strapped down into passivity. We were NICE to them, but they could not be active in their labor/births." (MT2)
Q21	Respectful Environment Even when dismal	Privacy was addressed by several respondents constraints of practice site, degree of MD support, culture of staff and hospitals "a lot of awareness about this and we tried to protect them as best as was possible" (MT2)
Q22	Family as Primary Support REspeccting this	"cultural differences were put as low priority" (MT2) limits were set by institutional protocols as to who supported woman in labor/birth Outlier - "...fostered woman's dependency on them and made themselves indispensable To her...[seemed to] derive emotional fulfillment and self-esteem from being so Important to the women." (MD3) "[midwife] still primary "expert"
Q23	Confidentiality	One of few questions with balanced response 3 respondents said it was observed 4 observed infractions "frequent discussion in public places" (MT3)

		"too much discussion at lunch" (MT2) "discussed clients with staff"(MT2) "minor breeches in teaching hospitals" (MT3)
Q24	Adapting to Cultural needs	Similar lack noted as identified in previous answers Not always good fit - culture of midwife not always a match with women – language obstacles
	Avoid routinizing	"too busy – routine valued over women's needs…" (MT3) "don't think that anyone is really great at this" (MT2)
		Outlier: "We tried to adapt as best we could but sometimes a woman's cultural or emotional needs were not congruent with what we felt to be good health advice." (MT2)
		"At what point does patient's culture help/hinder US AMA type of care?" (CT3)
		"sometimes patient's needs are unrealistic and can't be met." (CD3)
		There were 5 of 21 respondents whose experiences were particular cultures and they felt that this was observed at their sites
Q25	Wholistic approach	environments cause fragmentation of care - too often "medical model" only acceptable model
Q26	Involve family And/or SO	Varied with policies and location
Q27	Accessible	9 of 11 respondents did not observe this in practice – similar constraints – census, location of Practice
		Several observed that midwives are "too accessible' at the expense of their families This is also reflected in Q39 where all respondents felt that midwives did not lead Balanced lives
Q28	Provide	16 of 21 observed that this varied with location but that volume, work load, and time prevents

	Adequate time	midwives from practicing this way "busy busy busy " one or more of this term was used by most respondents
Q29	Education and Information	PN most often time when education provided but limited to 10 min visits so adequacy of education and information limited to hand outs "difficult in settings with multiple cultures" (MT3) Reflective comment – "Some people get overwhelmed with 'all the facts' – a lot of people just want you to give them your educated recommendation" (CD3)
Q30	Informed consent	While this was another question that was balanced in observation – most felt that "true" Informed consent was not always done – and patient's understanding of what they were Signing was not always clear. "only for operative procedures" (CT3) "Ha!...please sign here" (MT2) "true informed consent rarely done" (MT2) "many times women were told something was needed without discussion of risks/benefits or alternatives or given space to think about their 'permission'..." (BAT3) Reflective comment – "prefer the concept of informed choice" (CD3)
Q31	Listening to Women's voices	"listening wasn't bad, it was responding. Our hands were tied...women weren't very vocal or verbal..." (MT2) "didn't provide interpreters so couldn't always know the woman's voice" (MT2)
Q32	Partner with woman	Only 4 respondents gave observations – 100% felt partnership was not observed "we had the white coats and she was

		passive/dependent....not much done to change that...what were we going to do with an uppity woman..." (MT2)
		"during pushing" (MT2)
Q33	Helping woman Draw on inner strength	7 of 9 respondents did not observe this
		"not during L&D – drugs did it." (CT3)
		"Not much strength needed when 90% have epidurals" (MT2)
		"tried...[in hospital environment]...but it was like pushing a rock uphill" (MT2)
		"this is an uphill battle because the socio-cultural-medical climate dictates to women [what] they should want...they want a doctor"
Q34	Advocacy for women	Another question with balanced observation
		"job security made no one willing to stick out their necks and speak up for anything besides hospital protocols" (MT2)
		"as long as it was norm and OK with the nurse" (MT2)
		"difficult to do...MDs did what they wanted"
		"CNMS very protective of the woman against any predators..." (MT2)
		"when woman transferred to MD care, midwife stayed as doula (MTBC) and negotiated hospital structure..."
		" she was not afraid to disagree [with MD]" (MT3)
Q35	Gentleness	5 of 7 respondents observed this in practice
		"very sensitive practice – Pap, cultures, etc" (CD3)
		"absolutely" (MD2)
		"overall sensitive [except for one]" (MT2)
		"they were great at this" (MT2)
Q36	Updating own	This question had a number of responses that were qualified

	Professional Knowledge	– constraints to making this part of practice were primarily time, census, and finances Some respondents observed that midwives attempted to do this through home study Offered by ACNM, through journal reading, on site educational presentations, grand rounds Several felt that materials available were too old, outdated, and that they thought Midwives should attend conferences more
Q37	Reflective Practice	Another question with balanced observations Constraints – "turmoil in practice – not reflective atmosphere" .Status quo –"did what they have always done and getting them to change was difficult" "yes to understanding but no to improving practice" done in a variety of ways…weekly conferences to review difficulties, peer review, precepting students, clnical rounds, discussing each labor (with students)…
Q38	Peer Review	6 of 10 respondents did not observe peer review as outlined by ACNM documents Internal chart reviews was the most common method of peer review or not done at all "consulted each other" (CT3) "some practices did this more than others" (MT2)
Q39	Balance in life	19 of 25 respondents felt that most of the time midwives sacrificed personal and family needs to practice midwifery "midwives left little time for themselves and their personal lives" ((MDHB) "no emphasis on balance" "most were burnt out and overstressed" (MT2) "[midwife] had serious problems with this" (MT2) "overworked, underpaid, and not respected for the high quality of their care"(CD2) "every midwife I worked with seemed overwhelmed by the work situation" (MT2)

This was true for solo midwives and small practices but also true for all places of practice –Hospital, birth center, home birth, solo birth

Summary

Of the 410 surveys questionnaires sent to the addresses of newly certified CNM provided by the ACNM, 245, or 60% responded, which would indicate a strong interest in this topic, and potentially a desire to ventilate recent emotions. As per this researcher's experience in midwifery education, potential applicants to the profession usually enter this field answering a strong desire to "make a difference" in maternal health by helping to support normal labor, enhance the decision making power of the mother in childbirth, and create an environment that is supportive of this mission. The student's final clinical experience (Integration) is thus an important professional time, where the qualities of exemplary midwifery should become integrated and part of the new practitioner's package.

The question this survey was attempting to answer was : "Is exemplary midwifery really observed by students?" One must note that the sample chosen was not randomly assigned through many years or stratified to equal programs and clinical settings, so one must remain skeptical as to the wisdom of generalization. Midwives do practice in numerous types of settings many of which were not represented here. However, the intent of the study was to provide an overview of the clinical settings and types of midwifery education, including the fast growing distance education options. The study's attempt was to determine if there was congruence between the espoused theory of midwifery,

including midwifery students and the theory-in-use implemented in practice by preceptors.

The overall scale values by percentage for high emphasis of 6 and 7 of Ideal perception for all respondents was 93% and Actual observation of the same high emphasis was 54%, the difference between the two values being 39%.The large percentage of responses to high emphasis of the Ideal perception of exemplary midwifery process confirms the previous assumption that students chose to become midwives because of the perceived attributes of exemplary midwifery. This relatively large difference between Ideal and Actual is the non-congruence between Ideal perception and Actual observation which this study are attempting to identify.

The dimension "Being Gentle" was the only one of the 39 where there was congruence between the Ideal perception and the Actual observation by respondents during their last clinical experience.

When analyzed in thematic groupings, dimensions of "Vigilance", "Respect the uniqueness of the woman" and "Respect the woman through he setting" achieved higher congruence, with a higher emphasis on actual observation by the respondents than the other two : "Support the normal process" and "Professional Issues" . None of the groupings achieved a difference smaller than 30.99% when looking at the gap between Ideal perception and Actual observation.

Relative to the comparison of means between various locations, such as types of education programs, various settings of clinical rotation or distance versus traditional education, statistical analyses guided the author in confirming true significance and in localizing non congruence.

Hypothesis number 1 , That there will be no difference between the respondents' espoused theory and that of the Delphi Experts on all 39 dimensions , was partially rejected and partially accepted. Most of the dimensions responsible for the difference between values of Experts versus values of respondents were described as potentially poorly experienced by novice midwives. Hypothesis number 2 , that there will be no difference between the espoused theory of Delphi Experts and the degree of emphasis of the observation of the Actual exemplary midwifery process by graduating student during last clinical experience/integration, on all 39 dimensions was rejected, except for one count, "Gentleness to women", which seems to have been observed with consistent emphasis in clinical practice.

Hypothesis number 3,that there will be no difference between the Actual observed process of Exemplary Midwifery during integration and the Ideal espoused midwifery theory of respondents , using thematic dimension groupings, was rejected, Hypothesis number 4 , that there will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home Birth Practice, Birth Center, Level 1&2 hospital, or Level 3 hospital, was partially rejected and partially accepted, the Birth Center being identified through the Tukey test as the variable with a significant difference for the grouping "Support the normal process" and Home Birth identified as the setting with a significantly different mean for the grouping " Vigilance and attention to details". Hypothesis number 5, that there will be no observational difference between the respondent's observation of exemplary midwifery process and types of educational programs, i.e. Certificate, Masters, BA to BSN to CNM or AD to BSN to CNM, was also partially rejected and partially accepted, with the BA to BSN to

CNM type of program providing the significant difference for three of the groupings, "Respect in the setting", "Vigilance and attention to details" and "Professional Issues" . Hypothesis number 6, that there will be no difference between the observed emphasis on exemplary midwifery process by respondents from Traditional Programs, (on site) versus Distance-Learning programs (web-based or others), was rejected, both distance and traditional program having no significant difference in their means.

The qualitative results of the survey lead us to summarize it in this final comment: The comments offered by the respondents illuminated and reflected the level of emphasis given the 39 dimensions . Some generalizations can be identified that will be further explored in chapter V. Implementation of Espoused theory in the clinical setting is often compromised by many situational factors , from practice location to internal midwifery group dynamics, leaving clinicians swimming upstream in a cultural environment of birthing traditions and status quo.

CHAPTER V

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Theory-practice gap is a universal professional education dilemma. Having found a niche in Institutions of Higher Learning and having benefited from participation in its research and collegiality, professional education is reluctant to detach itself from this affiliation and focus its educational need on student acquisition of skills.

Theory-practice in Teachers Education has been the subject of recent studies using Schon's theory of Reflection on Action as theoretical framework to undergird reflection on action in teachers' education. Trends for the last three years for professional development continue to show the positive relationship of mentoring to professional outcome , including advancement, satisfaction with one's job and empowerment.(Welsh, 1996)

Possible solution to the problem of narrowing the gap between theory and practice in teacher's education has been the designation of certain schools by the school district . These school would be used as induction school to provide internship to beginning teachers. (Wise,Darling-Hammond,Berry, Berliner,Haller, Praskac & Schlechty 1987) . The American Federation of Teachers has implemented pilots of professional practice schools.

Several organizations, including the Carnegie Report, The U.S. Department of Education, The Senate Labor and Human Resources Committee have suggested the implementation of such teaching schools. According to Goodlad (1990) " Although it incorporate

elements of each, the Professional Development School is meant to be more than a laboratory school, a model school, or a setting for clinical supervision of novice teachers. It is considered to be a new institution (Holmes, 1990)

As models for developing exemplary teaching practice, Professional Developmment Schools become the best location for clinical practice and role modeling in the education of future teachers.. " There is considerable evidence that teachers consider their student or practice teaching experiences to be the most powerful element in their professional preparation" (Goodlad, 1990) .

Todays schools do not prepare teachers ready for the task of teachi9ng well, which in turn do not prepare children to compete in a changing world. The structure of many public school inhibits knowledge-based teaching practice (as we have seen in midwifery practice: " Setting dictates practice") ; as a result, student learning is curtailed and teachers learning is inhibited.

There is an assumption that higher education has a moral responsibility to ensure well-educated teachers for America's schools. Goodland J. (1999).

Underscoring this assumption is the legacy that being a teacher is a right and that anyone who wishes to teach can do it with a minimum of preparation.Since we want our teachers to be well-educated and well prepared in the subject matters of their teaching, we must create curricula that will meet these challenges.

" For institution of higher education that decide to take the high road of leadership, there is some good news. There is now a sizable domain of fundamental agreement of what needs to be done if teacher's education is to become a robust enterprise" (Goodland 1999). The major elements of this agreements are : necessity for

school and university partnering, for involvement of faculty in the arts and sciences, for partner of professional schools serving as teaching schools, and " for these schools to renew together –hence the concept ot "simultaneous renewal" guiding the change strategy introduced by the American Association of Colleges for Teachers Education and the Holmes Partnership" (Goldman 1996) .

Reflective practice suggested by Pollard & Tann (1987) as the most appropriate model to improve professional competence for teachers, where a reflective teaching implies an active concern with aims and consequences, combine enquiry and implementation, is applied in a cyclical process in which teachers continually monitor their own practice. Theory-practice gap can be expressed as congruence versus non congruence between values that are espoused by the professional body and values that are currently used in clinical practice .

Summary of Purpose and Problem

Nurse-Midwifery has a long history of providing safe maternity care to vulnerable populations of women . They have often extended this compassionate care to the women's families and communities. Nurse-Midwives have assisted women who wanted to be more involved and empowered in the birthing of their children. They have supported and listened to their concerns and they have advocated and defended women's rights.

Because of their expertise in the support and nurturing of the normal birth, they have helped to significantly reduce the rate of operative deliveries in this country . They continue to provide a feminist voice in the often overly paternalistic world of the medical

profession, where maternity and birthing have inadvertently landed. Midwifery as a profession is facing a quiet crisis. The pioneers, who established the foundation for the profession in the United States in the early 1900's, are reaching retirement age or have already retired. The younger generation of nurse-midwives are re-defining their identity in a changing socioeconomic and political environment. An environment significantly different from their foremothers. They are looking for preceptors and mentors with the willingness and ability to transmit their skills and art.

The literature review indicated that the clinical teaching of midwifery values needed to be reevaluated. It also indicated that values could be taught. The teaching of professional values is an important step in socialization into a discipline. Non congruence between a profession's espoused theory and its theory-in-use can lead to lack of confidence and loss of professional power. Yet, no studies were found on the clinical implementation of exemplary midwifery values with the midwifery students.

This was an ex post facto study designed to discover if midwifery students' espoused theory of midwifery matched that of expert midwives and if dimensions of exemplary midwifery process were observed by graduating students during their final integrative clinical experiences.

Six Null hypotheses were statistically tested at (p=.05). Comments offered by the students were analyzed for common themes and general content .

Instrumentation

Demographic data was collected on the participants. A questionnaire was developed using "dimensions" of exemplary midwifery process isolated in a Delphi study conducted in 1999 (Kennedy 2000) . The Delphi study asked expert midwives what they considered

exemplary and unique about nurse-midwifery. Those isolated dimensions were used as 39 statements of exemplary midwifery process in the questionnaire. A likert two-lined scale from 1 to 7 was devised to capture the degree of emphasis the respondent placed on the ideal process (upper line of scale) as compared to what they actually observed in their final clinical experiences (bottom line of scale). The scale ranged from no emphasis (1) to high emphasis (7). In addition, each question offered the respondent an opportunity to write additional comments below each question in order to clarify or explicate their choice of emphasis. The design of the questionnaire allowed the researcher to compare the perceived ideal midwifery process (values) of the students with those of expert nurse-midwives. It further examined the experience the student had in observing whether the ideals of midwifery (espoused theory) were observed in their own experiences with clinical educators (theory in use). Demographic data allowed the researcher to examine if there were differences in these perceptions of espoused theory and theory in use among different educational preparations as well as sites of nurse-midwifery practice.

Following the guidelines for research review from the American College of Nurse-Midwives, Division of Research, the researcher received approval for the mailing list of all the newly certified midwives for the year 2001. The questionnaire was sent to 410 new midwives, together with a self addressed stamped envelope and a token button with the words "Listen to women" inscribed in white on blue . After two mailings, 245 questionnaires were returned (60% return rate). Data was collected during the Winter and Spring of 2002, and was entered on SSPS 7.5 . Respondent's additional comments and clinical examples were entered as narrative using WORD 98 for content analysis.

Result Overview

Overall Overview of Frequency

A description of the study sample (N=245) revealed that most graduates (66.5%) attended a Masters programs, 26.1% attended Certificate Program, and 6.9% attended a program that offered a bridge from BA to BSN to CNM. Only 0.4% of graduates attended an AD to BSN to CNM educational program. Of the above programs, 69% were Traditional, on site, and 31% were Distance Programs , using accredited web or mail-based educational models. Students received their final clinical teaching experiences in Level 1&2 Hospitals (49%), Level 3 hospitals (38%), Birth Centers (10.2%), and in Home Birth Practices (2.9%). The generous return rate indicated a keen interest and potential concern for an emphasis on exemplary midwifery process in actual practice, especially as new nurse-midwifery graduates are often uprooted and overwhelmed in seeking and beginning new careers.

Data ranked by frequency and percentage of Actual Observation of exemplary midwifery by students indicated that although more than 80% observed a high emphasis on the highest ranked dimension of "Being Gentle", it clearly left close to 20% who did not observed any high emphasis at all on this dimensions of exemplary midwifery.

The 39 dimensions were then grouped into thematic clusters of five "groupings": (a) Vigilant and attentive to details, (b) Support the normal process of birth, (c) Respect the uniqueness of the woman, (d) Respect the woman through the setting, and (e) Professional Issues. Using these groupings the researcher identified a trend. Dimensions

of Vigilance and Respect were ranked higher (60.42%-62%) and Supporting the normal process of birth and Professional Issues were ranked lower. (40.5% - 41.29%). Supporting the normal process of birth, which is the hallmark of midwifery care, did not ranked higher than 20th (54.3%) among the 39 dimensions . It was still the highest ranking of the dimensions that comprise this grouping (Therapeutic: Support the normal Process of birth), with the 9 others , Use Natural Resources, (rank 22th), Personalizes care (rank 26th), Considers all options (rank 29th) , Uses appropriate Interventions (rank 32nd), Uses Wholistic approach (rank 34th) , Uses low tech approach (rank 36th) , and rapidly cascading down , we find the last two dimensions of this grouping, Being patient, 37th, and Using Wide resources, 38th. High emphasis was placed on observing the dimension of "appropriate interventions" by 38.3% of the respondents. That leaves the impression that more than 60% of the respondents did not observe a high emphasis on "appropriate interventions" , which would be incongruent with the significant emphasis given this dimension by expert nurse-midwives in the Delphi study and also incongruent with espoused "exemplary midwifery practice" perceived as deserving high emphasis by 93% of respondents.

While the nurse-midwifery profession continues to research the use of natural or alternative resources such as ambulating in early labor, use of position for both maternal comfort and speed of progress, to promote a healthy maternal/infant outcomes, there is consensus that "Being Patient" is a requisite for enabling and supporting the birth process to unfold naturally using the woman's own normal physiological and psychological processes. However, the respondents ranked "Being patient" (rank 37th) , next to last, on the list of 39 dimensions. Additionally, nearly 60% of the respondents

reported never observing, in actual practice, any high emphasis on this exemplary dimension. A confounding variable related to this response may be that the respondents were novice professionals who evaluated their observations from a different experiential perspective, ie. Fewer years in practice and less likely to identify when patience was appropriate and when intervention was prudent

An overview of the groupings revealed that Vigilance and Respect were observed with almost equal emphasis (62% and 61.83%) across all educational practice settings, while Respect for the Uniqueness of the woman was observed at 60.42% also across all settings. This suggests that almost 40% of the respondents did not observe a high emphasis on these dimensions (vigilance, respect in the setting , and respect for the woman's uniqueness).

Respondents ranked "Supporting the normal process", next to last, at 41.2% , and "Professional issues" the last one, at 40.5%. Also, 8-18% of the respondents observed a low to very low emphasis on the implementation of these dimensions by their clinical educators. It is unclear to the researcher why the respondents would rank both of these at the lower end of the scale. Understandably, Professional Issues, more concerned with non patient contact elements, might rank lower from a students perspective, being more difficult to observe. It raises significant concerns, if indeed, the respondents did not observe clinical educators "Supporting the normal process of birth" in actual practice. This dimension is widely believed to be the caveat of the profession of nurse-midwifery.

Congruence or Lack of Congruence

If one defines incongruence as the gap between two events, one can examine the gap between the Ideal perception of values related to exemplary midwifery by graduating

students and their Actual observation in the difference in emphasis placed on each dimension during their final clinical education experience.

The ranking of the difference between Ideal perception and Actual observation of the 39 dimensions revealed that , "Being Gentle" ranked first, with a difference of .49 between the mean of Ideal and Actual , making this dimension the most congruent compared with the other dimensions. " Appropriate Interventions" part of the grouping "Supporting the normal process" ranked last with a difference of 1.74 between the Ideal and the Actual mean.

The highest ranking for the grouping: "Therapeutic: support the normal process of birth " is the dimension "considers all option" , ranking 26^{th} with a difference of 1.34 between the Ideal and Actual mean on emphasis . A cluster of all 8 remaining dimensions rank very low between 29^{th} and 38^{th} among all 39 dimensions. .

A closer look at the five Groupings ranked by the difference in percent for high emphasis of 6 and 7 on the scale (see table 4.10) shows Vigilance has having a difference of 30% between Ideal and Actual, ranking it most congruent group. Groupings concerned with dimensions of Respect ranked very close at 32.2% and 32%, reflecting a next to similar congruence between expectations and actual observation. This again leaves us to ponder the fact that a difference of 30% is a noticeable gap between what is perceived as exemplary and what is actually observed and that there is reason for initiating a closer look at this potential problem.

The grouping: Support the normal process , in the difference between Ideal perception and Actual observation demonstrated the widest gap of all, with a 50.4% difference on expected high emphasis and the high emphasis actually observed.

It appears that supporting the normal process of birth, while strongly advocated by both experts and students as a beacon of exemplary midwifery process was poorly implemented or was perceived as poorly implemented by the students, during their final clinical experience.

Summary of Hypotheses Testing

The six null hypotheses were tested as follows: Hypothesis 1, that "there will be no difference between the respondent's espoused theory and that of Delphi Experts on all 39 dimensions" was tested by a one-sample t-test; Hypothesis 2, that "there will be no difference between the espoused theory of Delphi Experts and the degree of emphasis of the observation of Actual exemplary midwifery process by graduating students during last clinical experience/integration", was tested with an independent sample t-test; Hypothesis 3 ,that "there will be no difference between the Actual observed Exemplary Midwifery process during Integration and the Ideal espoused midwifery theory of respondents ,using thematic dimension groupings" was tested using a paired t-test; Hypotheses 4, that "there will be no association between the extent of implementation of exemplary midwifery process and type of clinical setting, such as Home birth practice, Birth Center, Level 1&2 Hospital and Level 3 Hospital", and Hypothesis 5, that "there will be no observational difference between the respondents' observation of exemplary midwifery process and types of educational programs. i.e. Certificate, Masters, BA to BSN to CNM , or AD to BSN to CNM", were tested using ANOVA. Hypothesis 6 , that "there will be no difference between the observed emphasis on exemplary midwifery process by respondents of Traditional Programs , (on-site) versus Distance -learning

programs (web-based or others)" by an independent sample t-test. Results for the six hypotheses can be found in Table 5.1.

Table 5.1

Results of the Null Hypotheses Tests

Test	H_1	H_2	H_3	H_4	H_5	H_6
t-test (one sample)	PA/PR at .01 or .05.....					
t-test (one sample)	.....	.PA/PR at .01.....				
t-test (paired)	.....	R at .01.....				
ANOVA	.....	PA/PR at .01.....				
ANOVA	.....	PA/PR at .01..... .				
t-test	.....	A at .05				

A=Accepted; PA/PR = Partially accepted, partially rejected

The dimensions that were different from the Delphi experts were found to be ranked higher by the students, except for five, Doing on-going assessments, Supporting the normal, Practicing confidentiality, Listening to the woman's voice and Using reflection in practice, which ranking lower could be explained by the student's lack of professional experience.

There were significant differences for Hypothesis 4 and 5 between the various groups forming thematic clusters of exemplary dimensions, therefore, Tukey HSD was used to query where the difference in means was most represented. In Hypothesis 4, "Supporting the normal process" was observed with significantly higher emphasis in Birth centers, "Vigilance and attention to details" received less emphasis in Home Birth

Practices . In Hypothesis 5, groupings of "Vigilance and attention to details", "Respect of the woman through the setting", and "Professional Issues" were all observed with lower emphasis by respondents from BA to BSN to CNM educational programs.

In summary, the respondents' espoused theory of midwifery mostly surpassed in high emphasis of exemplary dimensions that of expert midwives. Dimensions of exemplary midwifery process were observed with various degree of high emphasis by the respondents during their last clinical experience, with some incongruences noted. The purpose of this study was to determine if there is congruency between midwifery's exemplary process and the espoused theory of graduating students, and to which extent the values of exemplary midwifery process are observed by midwifery students during the student's final clinical experience ; the results of this study indicate that the purpose was met.

Discussion

The timeliness of this study, investigating the congruency between what midwives perceive as exemplary practice and what their students observe in actual clinical behaviors, is evidenced by a recent ACNM publication on concerns related to student recruitment and retention in the profession. Midwifery students are not the only professional group that report being frustrated between the ideals taught in their academic/didactic courses and their actual student clinical experiences, as well as in their actual professional environments. The results of this study should engage nurse-midwives in a professional dialogue on how to educate practitioners with enough professional power to put their espoused values into actual professional practice.

Strategies are needed to address the incongruities found in this study. If, indeed, we are unable to support the normal process of birth in actual practice , a highly esteemed nurse-midwifery value, then we must seriously address the barriers that prevent us from "practicing what we preach". The focus on evidence-based practice challenges the nurse-midwifery profession to demonstrate to health policy decision-makers that the ideals we espouse do, in actuality, result in better outcomes, improved satisfaction with care, and a decrease in health care costs. Only when we can provide evidence that these espoused dimensions of ideal practice make a difference will we be able to practice the ideals. Nurse-midwifery educators are further challenged to address these incongruities in their educational programs.

The recent crisis in health care, where fiscal constraints have deflected necessary financial sources from needed health delivery system and driven practitioners away to other more lucrative or more fulfilling careers, have also clearly redefined the need to educate competent and self-confident midwives. A new generation of nurse-midwifery professionals able to provide affordable care focused on health promotion.

The concern of health professions with the clinical education and proper socialization of students in the ethical realm and understanding of their professional behavior code is evidenced by the amount of research published in this area in recent years. Little, if any, concern with this topic seems to have been voiced in years past, especially in such powerful professions as medicine. Much is written now about medical educators revisiting their own commitment to their professional oath and modeling the proper behaviors to students. Perhaps non–congruence between espoused medical theory of compassion and caring and theory–in-use of professional power and enormous

financial rewards have created the beginning of a decline in professional power as well as a loss of confidence in new physicians' ability to provide such care. With the introduction of managed care, the professional power of medicine has been increasingly challenged.

In the United States, it is difficult to make "professional values in practice" comparisons between the professions of medicine and midwifery. Midwifery has an international definition and recognition as a profession. However, the history of nurse-midwifery and professional midwifery, has a long historical oral and recorded tradition but is relatively young as a profession in the United States.

In the study of sociology of the professions, and in health professions in particular, one finds medicine as the center of the professional constellation, with other health related professions rotating in well-disciplined choreography. There is little use in trying to destroy and forcefully change this order of things, which has grown out of particular historical events and has answered a unique societal need. One can however, create an environment where the balance of the constellation is maintained by acquisition of more peripheral power and by the creation of increased professional energy. This acquisition of professional power and increased professional energy is partially dependent on matching a profession's espoused theory and its theory-in-use. Educating and socializing students into the art and science needed for the implementation of its espoused theory would be a needed first step.

In attempting to answer the questions raised at the beginning of the study, that the students espoused theory would match that of exemplary expert midwives, this author was surprised to find non-congruence. After years in professional nurse-midwifery

practice and in the education of a large numbers of nurse-midwifery students, this researcher has observed that aspiring midwifery students enter their course of study with well-defined ideological goals of providing true midwifery care and making a commitment to changing the status of women within the maternity /family medical approach. Non congruence in the sets of values was tempered by the fact that students ranked the exemplary behaviors even higher than the expert midwives except for five of them, which could be attributed to the students lack of professional exposure and experience. One must bear in mind that even when significantly different, these dimensions of exemplary midwifery process were given very high emphasis by respondents , which means that students enter the profession having already identified and valuing highly the dimensions of exemplary midwifery.

Reflecting on hypothesis 2 , one is again forced to note the almost total non congruence between the expected behaviors of exemplary experts and the respondents observation of their actual implementation while engaged in their own clinical education and socialization into the profession. Some dimensions were represented with greater emphasis at a higher frequency, and there is some reassurance in noting that both vigilance and respect to the woman were observed throughout the clinical rotation. Vigilance is necessary for safety and midwives have had to demonstrate and validate the safety of their clinical protocols in order to maintain their professional niche. However, it was somewhat disconcerting to find the mean for the Actual emphasis in the dimension of Vigilance as low as 5.75 . It was a behavior rated at 6.41 by the Experts. The dimension " Being gentle" has found in congruence, as it appears to be reflected by both Ideal and Actual with significant high emphasis.

Tests on Hypothesis 3 resulted in complete non-congruence between Students expectation in Ideal exemplary behaviors and the Actual observation of these same behaviors in their clinical experience .

This study reflects the self-reported observation of new graduates reflecting on student clinical experiences. Results are limited in that they may not reflect potential biases held by the students , their identification with or in opposition to particular practitioners, or that they may have remembered special circumstances that were outlier experiences. By asking for observation of direct behaviors, the study wanted to remain focused on the actual aggregate of preceptorship, which becomes an abstract construct. In asking for direct observation, the study wanted to avoid interpretation by respondents , which would have created another version of espoused theory. (Argyris & Schon, 1974) .

Hypothesis 4 compared the means of Actual observation in various clinical settings. Significant differences for two of the groupings were found. Using Tukey HSD, Birth Center setting demonstrated a significantly higher mean in Actual observation for the thematic cluster on "Respecting the Normal Process of Birth". "Vigilance and attention to details" was observed with significantly less frequency in Home Birth setting. The means of all other groupings did not differ significantly from each other. This implies that all dimensions related to Respect and Professional issues were observed with equal emphasis in all clinical settings.

Results on hypothesis 5 demonstrated that the mean for the thematic groupings "Vigilance and attention to details", "Respect through the setting", and "Professional issues" differed significantly among the three types of nurse-midwifery educational programs. Vigilance was significantly lower in the BA to BSN to CNM programs;

Respect and Professional Issues were also significantly lower in the BA to BSN to CNM programs. Actual observation of these above mentioned exemplary midwifery dimensions were reported as observed with less emphasis by graduates from these types of programs.

Results on Hypothesis 6 demonstrated no significant differences in Actual Observations from students of Traditional or Distance learning on all of the five thematic groupings of the 39 dimensions.

Discussion of Qualitative Analysis

The final answer, to the question "If you found that your clinical experience did not match what should have occurred, please indicate what factors might have contributed?" two hundred respondents checked at least one of the answers, the majority found that lack of private time was a contributing factor. Interference in hospital setting was the second most frequent , at roughly one third. Lack of follow up and not enough time were about equally divided at 25%. It is interesting to note that "Lack of private time" was considered a significantly important factor to the student's dissatisfaction with the overall experience of the last clinical rotation.

Most programs are condensed into one or two years or so allowing a hiatus from remunerative employment to be as short as possible . This researcher was not aware that the intensity of the curriculum colored the quality of the satisfaction with clinical picture to such an extent.

Content Analysis of Open-Ended Question

The invitation to add additional thoughts at the end of each of the 39 question were answered by many more participants than was expected (at least one comment in 80 % of returned completed surveys) . Did the dimension/questions stir such emotional feelings as to compel the recent graduates to explicate their choice of emphasis further? The response rate to the questionnaire was (60 %) and of this group most provided additional comments, some quite extensive. These respondents also identified limited time as an important variable in their reflections on observations in actual practice. Content analysis identified location of practice significantly influenced the respondents perception of why what they valued in clinical practice could not be followed through in actual practice. Level 1-2 and Level 3 hospitals were significant barriers to "practicing what was preached" in the classroom. Practice location was commented on 134 times and clearly dictated professional behaviors of the practitioners. In effect, as one respondent commented, in the real world of professional nurse-midwifery practice "Espoused theory does not guide actual practice, the location of services and medicalized as well as institutionalized protocols dictate practice". Location of practice seems to impact significantly and negatively on the experience of students, on the desire to implement espoused theory into practice by clinicians and educators, and on lack of congruence between espoused theory of nurse-midwifery and actual observations of recent nurse-midwifery graduates, both in reflecting on their student experiences and in their sharing of professional real-life experiences post-graduation. Looking at each dimension individually, and then more globally in the light of the five thematic

groupings, again, the theme of Practice location appears to dictate the amount of emphasis placed on each dimension.

Recommendations

Further research is clearly needed to validate the questionnaire completed in this study and potentially use it as an instrument to measure clinical teaching effectiveness in nurse midwifery education programs. Other professions, also concerned with the unreliability of clinical teaching have created instruments to capture the more elusive aspect of professional mentoring. Copeland and Hewson, (2000) have developed an instrument used at the Cleveland Clinic in all medical departments across the institution to improve clinical teaching effectiveness and provide positive and negative feed back to the clinicians. In England, Fitzpatrick, While and Roberts (1996) have implemented the use of the Slater Nursing Competencies Rating as an effective instruments to explore nursing performance. Closer to our purpose, Fullerton ,Piper & Hunter (1993) developed the "Faculty Impression Score" to evaluate clinical performance in midwifery . All have a desire to evaluate with reliability and validity the clinical performance, not only of student but also of clinical preceptors.

Methods in assisting preceptors in developing skills necessary to effective mentoring of midwifery values also need to be researched. Critical thinking, the cognitive framework upon which most clinical decisions are based, has always created controversy in professional epistemology. Preceptors need be aware that critical thinking has an important affective component that is needed to integrate professional values into practice. (Woods, 1993).Medical faculty development integrating theory-based

principles of adult and clinical teaching have been successfully implemented at the Cleveland clinic. (Hewson, 2000). Further research is needed in acquisition of specific coaching skills (Grealish, 2000).

American College of Nurse-Midwives has identified the hospital as the place where most of the midwives certified by its certifying Agency are employed. Most midwives are also engaged in the care of vulnerable under-privileged women. The Delphi study did not specify the place of work of the exemplary midwifes participants. It would be informative to tap the group of midwives involved with that population and define their espoused theory of midwifery . Would theirs differ from the Delphi's espoused theory?

Discrete parameters for the dimensions of exemplary midwifery need be identified through Evidence –based research (Rooks, 1999) and validated in midwifery practice/process. This would assist in defining exemplary implementation in the clinical settings.

Non participant observation is a powerful method of inquiry in Action research, where theory-in-use can be made explicit by directly observing the participants' actions . (Argyris & Schon 1974) . Non participant observation has been used by medical researchers to evaluate the extent of modeling of medical ethics and values by clinical faculty (Hafferty & Frank 1994) .Non participant observation using videotaping for validation is a useful tool in midwifery practice research , given the serendipity of clinical encounters.

The use of journaling (keeping a diary) has been used by researchers in advance nursing . (Richardson 1995) Content analysis of reflective journals written by students

reporting on clinical events allowed themes to emerge. These themes could be validated through focus groups or other less structured group discussions and allowed to become more explicit. Espoused theory of advance nursing practice could then potentially be compared to its implemented theory-in-use. Midwifery students could, by keeping a reflective clinical journal, enhance their awareness of congruence between espoused theory and midwifery theory-in-use. Events responsible for the lack of congruence could be identified and confronted.

Other professions with a well defined espoused theory would benefit from an assiduous observation of their clinical behavior and an in-depth analysis of the mentoring competence of their clinical preceptors. Medical schools,facing an erosion of their professional power of managed care, are looking critically at the mentoring of their students in the values reflecting their professional oath. Loss of professional power through burnout accelerated by bureaucratization and lack of autonomy is defining poor job satisfaction among social workers. (Arches 1988). It is proposed that government policies re-integrate autonomy and creativity in the profession of social work. . Congruence between the espouse theory of social work and its theory-in-use could lead to a further loss of professional power and self esteem.

Higher education and professional education have both seen exponential globalization since the event of distance learning possibilities. Questions have been raised as to the wisdom of such a teaching modality . Discomfort of older, less flexible faculty, difficulty in quality control, lack of possible socialization into a academic culture, cost, all these questions and many more were and continue to be raised. Certain facts are very clear. Distance learning breaks time and location barriers. Professional schools , albeit

more reluctantly, have joined the global market. Difficulties are of a different nature: How do you transmit clinical knowledge, or other practicum curriculum through a web based course?

This study ,although pertaining to one professional group only, has clearly defined location of clinical practice as the agent responsible for the implementation of espoused theory. In this study, there was no significant difference between what was clinically observed by Traditional vs distance learning students. A careful assessment of clinical sites by Distance learning program would deliver the same quality clinical education as a Traditional model.

Based on this study's findings, the following suggestions for further research into improving congruency between Ideal /Espoused theory of exemplary midwifery and the Actual/theory-in-use behaviors observed by students, are offered:

1. Continued refinement of the questionnaire and potentially use it as an instrument to measure the effectiveness of midwifery clinical education
2. Identify which behaviors are associated with the implementation of safety (As reflected in the dimensions of Vigilance and attention to details) and seek to determine how and where they are not practiced ,or so perceived, by students.
3. Continue to probe into discrete behaviors associated with the dimensions of exemplary midwifery, using such techniques as journal writing and Action research, as proposed by Argyris and Schon by using video-taping and validation by the participants.
4. Validation of the videotaped events could lead to further research in reflective teaching and learning (see Schon).

5. However improbable or difficult the task may be, midwifery might want to take a closer look at its goals and mission. Survival of the profession is paramount to the continuity of care given to women and to the successful trends initiated in maternity care. Survival of the profession is dependent on professional power.
6. Prepare and support clinical preceptors in the task of mentoring students through the acquisition of congruent midwifery values
7. A new Delphi study might target exemplary midwives working in hospitals and perinatals centers potentially changing the dimensions of exemplary midwifery as viewed by those midwives, who represent the majority in this country.
8 Assessing qualified applicants to midwifery programs with respect to their espoused theory of midwifery to assist them in making a smoother and more dignified transition into practice.
9. Expanding the findings to the greater realm of general professional education , it is imperative for professional survival to monitor more closely the clinical education in regards to the implementation of espoused theory.
10. Continue to develop distance learning programs as a viable option for professional education. Focusing on the distance learning students' clinical experience is the platform on which socialization in espoused theory hinges.

Summary

Enhancing congruency between Espoused theory and Theory-in-use is one way to increase professional power , clinician's self confidence and professional survival.

There was significant non-congruence between the Ideal perception , both of Delphi experts and midwifery students, and the Actual observation of exemplary midwifery by graduating students during their last clinical experience (Integration).

Dimensions of exemplary midwifery related to "Supporting the normal process", and most non-interventive approaches were observed with the least frequency. Safety and respect were observed with the most frequency, but even then high emphasis was not present in a significant percentage of the respondents' observation.
Professional behaviors and issues were observed the least.

It was suggested from this study that in midwifery, practice location , not espoused theory dictates professional behaviors . Most of the students adding comments to their responses had negative experiences to relate. This might be expected, since agreement with the observed behaviors does not provoke such a desire to explicate the lived experience.

In our current competitive professional climate, as we continue to provide a quality general education from a recognized institution of higher learning, it is imperative to educate practitioners that will demonstrate justified clinical self confidence , true in-depth knowledge of their discipline, and (tempered) respect for the espoused theory of their profession .Acquiring the power to implement its exemplary dimensions would mean a much enhanced chance at professional survival.

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Appendix A

Solicitation Letter

January 19, 2002

Dear Colleague:

As part of my Ph.D. dissertation requirements at Seton Hall University's College of Education and Human Services, Department of Educational Administration, I am conducting a national survey of all newly graduated nurse-midwives.

My goal is to evaluate students' observation of exemplary midwifery during Integration. Completing the survey should take about 20 minutes .

This is how the help of each and every one of you would be most important: In taking the twenty minutes or so to fill in the questionnaire entitled: " Practicing What We Preach?" and adding your own comments or examples after each question, you will enable me to understand where and to what extent exemplary midwifery is observed by students during their integration. When filling the questionnaire, think of your "Integration" as a whole, as an aggregate of many preceptors. Try not to single any one in particular.

You have all studied and practiced at various sites, so each and every questionnaire returned counts toward a complete picture.

Your cooperation is completely voluntary . All data will be seen by myself only, and will be kept confidential. As soon as I receive your completed questionnaire , I will destroy the return envelope . I will keep the completed questionnaire in a locked cabinet in my office.

I am aware of the many demands made upon a newly graduated student and of the stress of completing a midwifery program . Your contribution will be of tremendous help for future generations of midwifery students and to the profession itself. I will be more than happy to share and discuss the final results with you

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights . The Chairperson of the IRB may be reached at (973) 275-2974

I thank you in advance for your cooperation and for your assistance in this study

Yours sincerely,

Ginette Lange

Appendix B

Follow up Letter

February 12th 2002

Dear Colleague:

I am aware of the many demands made on new midwives. It IS a most important time in your professional life. I am, however, resubmitting my request for your prompt return of the survey entitled " Practicing What We Preach?" that you received a few weeks ago, regarding the observation of exemplary midwifery in the clinical area.

Because midwifery is essentially a small professional body, I need every one of your precious responses to obtain valid data regarding clinical education. I also need your help in order to complete my doctoral dissertation, and facilitate the implementation of clinical curriculum here at my own institution.

I would be most grateful if you could take a few moments to complete and return this survey within the next few days . Again let me know if you are interested in the results, I will then be more than willing to share them with you.

Thank you for your help

Ginette Lange CNM FNP PhDc

Appendix C

Survey Questionnaire

PRACTICING WHAT WE PREACH?

A STUDY OF THE IMPLEMENTATION OF EXEMPLARY MIDWIFERY PROCESS

IN MIDWIFERY CLINICAL EDUCATION

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
To complete this survey, please circle the number for each item as described:

IDEAL Means how much emphasis you believe **should** occur in Exemplary Midwifery Practice

ACTUAL Means how much emphasis you **actually observed** in your final midwifery clinical experience (Integration)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

EXAMPLE:

Dimensions of exemplary practice		**Degree of Emphasis**						
		No Emphasis						**High Emphasis**
The exemplary midwife includes other modalities such as acupuncture, massage and therapeutic touch as part of routine care.	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**(7)**
	ACTUAL	**(1)**	**2**	**3**	**4**	**5**	**6**	**7**

Means you believe there <u>should be</u> a very high emphasis (7) on such modalities, but you did <u>not observe</u> any emphasis (1) during your integration

Some blank lines have been added after each statement to invite you to add comments helpful in clarifying your answer. For example:

YOUR COMMENTS:

_____

_____

_____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

		Degree of Emphasis						
		No Emphasis						High Emphasis
1. Being vigilant and paying attention to details	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

2. Documenting care very well	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

3. Doing thorough and ongoing assessments	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

4. Following up on care	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

5. Working to prevent problems	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

6. Practicing within a circle of safety	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

		Degree of Emphasis No Emphasis						High Emphasis
7. Consulting and referring appropriately	IDEAL	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

8. Being timely in clinical actions	IDEAL	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

9. Remaining alert to a changing clinical picture	IDEAL	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

10. Being adept at listening to one's own intuition	IDEAL	1	2	3	4	5	6	7
when responding to women's changing needs	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

11. Supporting the normal process of birth as a	IDEAL	1	2	3	4	5	6	7
healthy physiologic event, not as an illness	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

12. Intervening only if necessary and appropriate	IDEAL	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

		Degree of Emphasis No Emphasis						High Emphasis
13. Being patient, not hurrying	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	ACTUAL	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								
14. Using low technology approaches when possible	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	ACTUAL	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								
15. Drawing on a wide range of resources to tailor	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
a woman's care	**ACTUAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								
16. Considering all options when deciding on	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
on clinical management	**ACTUAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								
17. Drawing on natural resources when assisting	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
the woman, such as ambulation, nutrition	**ACTUAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								
18. Personalizing care, avoiding a one-fit-all	**IDEAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
approach	**ACTUAL**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
YOUR COMMENTS:								

		Degree of Emphasis No Emphasis						High Emphasis
19. Maintaining a supportive presence in labor	**IDEAL**	1	2	3	4	5	6	7
staying with the woman, as she desires	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

20. Providing positive encouragement and **IDEAL** 1 2 3 4 5 6 7

validation **ACTUAL** 1 2 3 4 5 6 7

YOUR COMMENTS:

21. Creating an environment that is respectful, even **IDEAL** 1 2 3 4 5 6 7

under often dismal external circumstances **ACTUAL** 1 2 3 4 5 6 7

YOUR COMMENTS:

22. Respecting the woman and her family, **IDEAL** 1 2 3 4 5 6 7

understanding the family's primary importance to the woman's support **ACTUAL** 1 2 3 4 5 6 7

YOUR COMMENTS:

23. Maintaining confidentiality, keeping from **IDEAL** 1 2 3 4 5 6 7

discussing cases publicly and/or carelessly **ACTUAL** 1 2 3 4 5 6 7

YOUR COMMENTS:

24. Avoiding routinizing care, adapting to the **IDEAL** 1 2 3 4 5 6 7

woman's cultural and emotional needs **ACTUAL** 1 2 3 4 5 6 7

YOUR COMMENTS:

		Degree of Emphasis No Emphasis						High Emphasis
25. Adopting a wholistic approach to care of the	**IDEAL**	1	2	3	4	5	6	7
woman	**ACTUAL**	1	2	3	4	5	6	7
YOUR COMMENTS:								
26. Involving the whole family and significant	**IDEAL**	1	2	3	4	5	6	7
others in her care, as much as she wishes	**ACTUAL**	1	2	3	4	5	6	7
YOUR COMMENTS:								
27. Being accessible and available to the woman	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7
YOUR COMMENTS:								
28. Making an effort to provide adequate time to	**IDEAL**	1	2	3	4	5	6	7
the woman's needs	**ACTUAL**	1	2	3	4	5	6	7
YOUR COMMENTS:								
29. Providing thorough education and accurate	**IDEAL**	1	2	3	4	5	6	7
information based on the woman's needs	**ACTUAL**	1	2	3	4	5	6	7
YOUR COMMENTS:								
30. Obtaining informed consent	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7
YOUR COMMENTS:								

		Degree of Emphasis: No Emphasis						High Emphasis
31. Listening carefully to the woman's voice and	**IDEAL**	1	2	3	4	5	6	7
responding appropriately	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

32. Working as a partner with the woman	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

33. Helping the woman draw on her inner strength	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

34. Advocating for the woman's needs	**IDEAL**	1	2	3	4	5	6	7
	ACTUAL	1	2	3	4	5	6	7

YOUR COMMENTS:

35. Being gentle with the woman when needing to	**IDEAL**	1	2	3	4	5	6	7
do uncomfortable procedures	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

36. Updating one's own professional knowledge	**IDEAL**	1	2	3	4	5	6	7
through journal reading and regular attendance at conferences and seminars	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

		Degree of Emphasis						
		No Emphasis						High Emphasis
37. Using reflection to understand and improve	**IDEAL**	1	2	3	4	5	6	7
clinical practice	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

38. Seeking peer review mechanisms to enhance	**IDEAL**	1	2	3	4	5	6	7
the quality of clinical practice	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

39. Bringing balance to personal and professional	**IDEAL**	1	2	3	4	5	6	7
life	**ACTUAL**	1	2	3	4	5	6	7

YOUR COMMENTS:

IN THE SPACE PROVIDED BELOW, YOU MAY WISH TO WRITE ABOUT A SPECIFIC EXPERIENCE WHEN YOU OBSERVED EXEMPLARY MIDWIFERY PRACTICED EVEN UNDER ADVERSE CONDITION, OR NOT PRACTICED DURING YOUR LAST CLINICAL EXPERIENCE /INTEGRATION
(PLEASE USE THE BACK OF THE LAST PAGE IF YOU NEED MORE SPACE)

PART 2

- WHEN DID YOU COMPLETE YOUR LAST CLINICAL EXPERIENCE/ INTEGRATION?

  MONTH_____ YEAR_____

- HOW MANY PRECEPTORS DID YOU HAVE DURING YOUR LAST CLINICAL EXPERIENCE / INTEGRATION? _____

- TYPE OF NURSE-MIDWIFERY/MIDWIFERY PROGRAM ATTENDED (CHECK ONE ONLY)

_____ CERTIFICATE

_____ MASTERS (POST BSN)

_____ AD-DIPLOMA RN TO CNM GRADUATE OPTION

_____ BA/BS TO RN/CNM GRADUATE OPTION

- DISTANCE/ ON-SITE LEARNING OPTIONS (CHECK ONE ONLY)

_____ TRADITIONAL (ON SITE)

_____ DISTANCE EDUCATION (WEB BASED OR OTHER)

- LOCATION OF LAST CLINICAL EXPERIENCE / INTEGRATION (CHECK THE ONE WHERE YOU SPENT MOST TIME)

_____ BIRTH CENTER

_____ HOME-BIRTH PRACTICE

_____ LEVEL 1 AND 2 HOSPITAL

_____ LEVEL 3 HOSPITAL

- IF YOU FOUND THAT YOUR CLINICAL EXPERIENCE DID NOT MATCH WHAT SHOULD HAVE OCCURRED, PLEASE INDICATE WHAT FACTORS MIGHT HAVE CONTRIBUTED (PLEASE CHECK ALL THAT APPLY)

_____ LACK OF FOLLOW UP

_____ NOT ENOUGH TIME

_____ INTERFERENCE IN HOSPITAL SETTINGS

_____ LACK OF PRIVATE TIME

Thank you so much for your time!

Appendix D

Core Competency for Basic Midwifery Practice

AMERICAN COLLEGE OF NURSE-MIDWIVES

THE CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE
MAY 1997

The core competencies for basic midwifery practice represent the delineation of the fundamental knowledge, skills, and behaviors expected of a new practitioner; as such, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy-makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited by the American College of Nurse-Midwives (ACNM).†

Midwifery practice is based on the *Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Nurse-Midwifery* and the *Code of Ethics* promulgated by the American College of Nurse-Midwives. Midwives who have been certified by the ACNM or the ACNM Certification Council, Inc. (ACC) assume responsibility and accountability for their practice as primary care providers.

Midwifery education is based on a theoretical foundation in the health sciences as well as clinical preparation which focuses on the knowledge, judgment, and skills deemed necessary to provide primary care and independent management of women and newborns within a health care system that provides for medical consultation, collaborative management, or referral as appropriate. Recognizing that creativity, innovation, and individuality, are essential to the vitality of the profession, each education program may develop its own unique identity and may choose to extend beyond the core competencies into other areas of health care. In addition, each graduate is responsible for complying with the laws of the jurisdiction where the practice of midwifery is conducted.

The ACNM defines the midwife's role in primary care based on the Institute of Medicine's definition (1994), the ACNM's Philosophy (1989), and the ACNM Board of Directors' Position Statement on Primary Care by Nurse-Midwives (1992). Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. Certified nurse-midwives (CNMs) and certified midwives (CMs) are often the initial contact for providing health care to women and they provide such care on a continuous and comprehensive basis. As a primary provider, the CNM or CM assumes responsibility for the provision of and referral for appropriate services within a defined scope of practice.

The concepts and skills identified below and the midwifery management process outlined in the sections that follow apply to all components of midwifery care and comprise the foundation upon which practice guidelines and curriculum content must be built. This document is reviewed and revised at least every five years to reflect changing trends and new developments in midwifery practice and must be adhered to in its entirety.

Hallmarks of Midwifery

The art and science of midwifery are characterized by these hallmarks:

- Recognition of pregnancy and birth as a normal physiologic and developmental process and advocacy of non-intervention in the absence of complications
- Recognition of menses and menopause as a normal physiologic and developmental process
- Promotion of family-centered care Empowerment of women as partners in health care
- Facilitation of healthy family and interpersonal relationships
- Promotion of continuity of care
- Health promotion, disease prevention and health education

† Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or ACNM Certification Council, Inc (ACC).

- Advocacy for informed choice, participatory decision-making, and the right to self-determination
- Cultural competency and proficiency
- Skillful communication, guidance, and counseling
- Therapeutic value of human presence
- Value of and respect for differing paths toward knowledge and growth
- Effective communication and collaboration with other members of the health care team
- Promotion of a public health care perspective
- Care to vulnerable populations

Components of Midwifery Care:
Professional Responsibilities of CNMs and CMs

The professional responsibilities of CNMS and CMS include, but are not limited to, these components:

- Knowledge of the history of midwifery
- Knowledge of the legal basis for practice
- Knowledge of national and international issues and trends in women's health and maternal/newborn care
- Support of legislation and initiatives to promote high quality health care services
- Knowledge of issues and trends in health care policy and systems
- Commitment to the ACNM's Philosophy, Standards, and Code of Ethics
- Participation in midwifery education
- Systematic collection of practice data to document midwifery care outcomes
- Ability to evaluate, apply, interpret, and collaborate in research
- Participation in self-evaluation, peer review, continuing education, and other activities that ensure and validate quality practice
- Development of leadership skills

Components of Midwifery Care:
Midwifery Management Process

The midwifery management process includes:

- Systematically compiling and updating a complete and relevant data base for the comprehensive assessment of each client's health, including a thorough health history and physical examination
- Identifying problems and formulating diagnoses based upon interpretation of the data base
- Identifying health care needs/problems and establishing health care goals in collaboration with the client
- Providing information and support to enable women to make informed decisions and to assume primary responsibility for their own health
- Developing a comprehensive plan of care with the client
- Assuming primary responsibility for the implementation of individualized plans
- Obtaining consultation, planning and implementing collaborative management, and referral or transferring the care of the client as appropriate
- Initiating management of specific complications, emergencies and deviations from normal
- Evaluating, with the client, the achievement of health care goals and modifying the plan of care as appropriate.

Components of Midwifery Care:
The Childbearing Family

I. Pre-Conception Care

A. Independently manages care of the woman who is preparing for pregnancy

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Reproductive anatomy and physiology related to conception

2. Impact of health, family and genetic history on pregnancy outcomes

3. Health and laboratory screening to

evaluate the potential for a healthy pregnancy

4. Assessment of readiness for pregnancy of the woman and her family including emotional, psychosocial, and sexual factors

5. Nutritional assessment and counseling

6. Influence of environmental and occupational factors, health habits, and behavior on pregnancy planning

II. Care of the Childbearing Woman

A. Independently manages care of the woman during pregnancy, childbirth, and the postpartum period

B. Applies knowledge of midwifery practice in the antepartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of conception, pregnancy and lactation

2. Diagnosis of pregnancy

3. Genetics, placental physiology, embryology, and fetal development

4. Epidemiology of maternal and perinatal morbidity and mortality

5. Influence of environmental and occupational factors, health habits, and maternal behaviors on pregnancy outcomes

6. Emotional and psychosexual change during pregnancy

7. Health risks including domestic violence, sexually transmitted diseases, substance, alcohol and tobacco use

8. Effect of maternal nutrition on pregnancy outcomes

9. Indicators of normal pregnancy and deviations from normal

10. Assessment of the progress of pregnancy and fetal well-being

11. Etiology and management of common discomforts of pregnancy

12. Management techniques and therapeutics, including complementary therapies*, to facilitate healthy pregnancy and outcome

13. Anticipatory guidance related to birth, lactation, parenthood, and change in the family constellation

14. Pharmacokinetics and pharmacotherapeutics of medications commonly used during pregnancy

15. Principles of group education

C. Applies knowledge of midwifery practice in the intrapartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the structures and processes of labor

2. Anatomy and physiology of the fetus

3. Diagnosis and assessment of labor and its progress through the four stages

4. Assessment of maternal and fetal status during labor

5. Indicators of deviations from normal including complications and emergencies

6. Measures to support psychosocial needs during labor and delivery

---

* Complementary therapies as used throughout this document refer to those therapeutic measures for which there is some evidence of safety and effectiveness.

7. Management techniques and therapeutics, including complementary therapies, to facilitate normal labor progress

8. Techniques for (i) administration of local anesthesia, including pudendal blocks, (ii) spontaneous vaginal delivery, (iii) third stage management, and (iv) performance and repair of episiotomy and repair of lacerations

9. Techniques for management of emergency complications and abnormal birth events

10. Pharmacokinetics and pharmacotherapeutics of medications commonly used during labor and birth

D. Applies knowledge of midwifery practice in the postpartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the puerperium

2. Emotional, psychosocial, and sexual changes of the puerperium

3. Postpartum self-care, infant care, contraception, and family relationships

4. Management techniques and therapeutics, including complementary therapies, to facilitate a healthy puerperium

5. Methods of facilitation or suppression of lactation

6. Deviations from normal and appropriate interventions including management of complications and emergencies

7. Management of discomforts of the puerperium

8. Pharmacokinetics and pharmacotherapeutics of medications commonly used during the puerperium

III. Newborn Care

A. Independently manages the care of the newborn

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Effect of maternal/fetal risk factors on the newborn

2. Anatomy and physiology of the newborn

3. Nutritional needs of the newborn

4. Bonding and attachment theory

5. Evaluation of neonatal status: (i) physical and behavioral assessment, (ii) gestational age assessment, and (iii) common screening and diagnostic tests performed on the neonate

6. Methods to facilitate adaptation to extrauterine life: (i) stabilization at birth, (ii) resuscitation, and (iii) emergency management

7. Promotion and management of breast-feeding

8. Indications of deviation from normal and appropriate interventions

9. Management techniques to facilitate integration of the newborn into the family

10. Pharmacokinetics and pharmacotherapeutics of common medications used in the neonatal period

Components of Midwifery Care: The Primary Care of Women

I. Health Promotion and Disease Prevention

A. Independently manages primary health screening of women through the life cycle

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology
2. Growth and development patterns for the woman across the life span
3. Basic principles of clinical epidemiology as they affect women's health
4. National defined goals and objectives for health promotion and disease prevention
5. Parameters for assessment of physical and mental health
6. Utilization of nationally defined screening recommendations to promote health and detect/prevent disease
7. Management techniques and therapeutics, including complementary therapies, to facilitate health
8. Pharmacokinetics and pharmacotherapeutics of immunizations

II. Management of Common Health Problems

A. Assumes responsibility for the triage of common health problems presented by women and for management, collaboration, co-management and/or referral to appropriate levels of health care services within the CNM's or CM's defined scope of practice

B. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and pathophysiology related to frequently occurring conditions
2. Etiology of common health problems of essentially healthy women
3. Parameters for differential diagnosis of common presenting health problems
4. Management techniques and therapeutics, including complementary therapies, for the treatment of common health problems of essentially healthy women
5. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for common health problems
6. Skills in health care team leadership and management to ensure that presenting health care concerns are addressed completely by a multi-disciplinary health care team and community services

III. Family Planning/Gynecologic Care

A. Independently manages the care of women seeking family planning and/or gynecologic services

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the reproductive systems, including the breast, through the life cycle
2. Human sexuality
3. Common screening and diagnostic tests
4. Parameters for differential diagnosis of common gynecologic problems including sexually transmitted diseases
5. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods
6. Management techniques and therapeutics, including complementary therapies, for common gynecologic problems and family planning needs
7. Counseling for sexual behaviors that promote health and prevent disease

8. Resources for counseling and referral for unplanned or undesired pregnancies, sexual concerns, infertility, and other gynecologic problems

9. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for family planning and gynecologic care

IV. Perimenopause and Post-Menopause

A. Independently manages the care of women during the perimenopause and post-menopause

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the systems as affected by the aging process

2. The effects of the menopause on physical and mental health

3. Nutritional needs of the aging woman

4. Common screening and diagnostic tests pertinent to the evaluation of the health of women with advancing age

5. Identification of deviations from normal and appropriate interventions

6. Counseling and education for health maintenance and health promotion in the aging woman

7. Management techniques and therapeutics, including complementary therapies, for alleviating the common discomforts that accompany aging

8. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications and treatments for the perimenopausal and menopausal woman

Source: Education Section, Division of Education
Approved by ACNM Board of Directors
May 31, 1997

(Supersedes *ACNM Core Competencies for Basic Nurse-Midwifery Practice*, February 1992)

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology
2. Growth and development patterns for the woman across the life span
3. Basic principles of clinical epidemiology as they affect women's health
4. National defined goals and objectives for health promotion and disease prevention
5. Parameters for assessment of physical and mental health
6. Utilization of nationally defined screening recommendations to promote health and detect/prevent disease
7. Management techniques and therapeutics, including complementary therapies, to facilitate health
8. Pharmacokinetics and pharmacotherapeutics of immunizations

II. Management of Common Health Problems

A. Assumes responsibility for the triage of common health problems presented by women and for management, collaboration, co-management and/or referral to appropriate levels of health care services within the CNM's or CM's defined scope of practice

B. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and pathophysiology related to frequently occurring conditions
2. Etiology of common health problems of essentially healthy women
3. Parameters for differential diagnosis of common presenting health problems
4. Management techniques and therapeutics, including complementary therapies, for the treatment of common health problems of essentially healthy women
5. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for common health problems
6. Skills in health care team leadership and management to ensure that presenting health care concerns are addressed completely by a multi-disciplinary health care team and community services

III. Family Planning/Gynecologic Care

A. Independently manages the care of women seeking family planning and/or gynecologic services

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the reproductive systems, including the breast, through the life cycle
2. Human sexuality
3. Common screening and diagnostic tests
4. Parameters for differential diagnosis of common gynecologic problems including sexually transmitted diseases
5. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods
6. Management techniques and therapeutics, including complementary therapies, for common gynecologic problems and family planning needs
7. Counseling for sexual behaviors that promote health and prevent disease

8. Resources for counseling and referral for unplanned or undesired pregnancies, sexual concerns, infertility, and other gynecologic problems

9. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for family planning and gynecologic care

IV. Perimenopause and Post-Menopause

A. Independently manages the care of women during the perimenopause and post-menopause

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the systems as affected by the aging process

2. The effects of the menopause on physical and mental health

3. Nutritional needs of the aging woman

4. Common screening and diagnostic tests pertinent to the evaluation of the health of women with advancing age

5. Identification of deviations from normal and appropriate interventions

6. Counseling and education for health maintenance and health promotion in the aging woman

7. Management techniques and therapeutics, including complementary therapies, for alleviating the common discomforts that accompany aging

8. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications and treatments for the perimenopausal and menopausal woman

Source: Education Section, Division of Education
Approved by ACNM Board of Directors
May 31, 1997

(Supersedes *ACNM Core Competencies for Basic Nurse-Midwifery Practice*, February 1992)

Appendix E

Thematic Groupings of the Dimensions

Grouping of the various Dimensions

Therapeutic:

Support the Normal Process of Birth :

Question #	Question
11	Supporting the normal process of birth as a healthy physiologic event, not an illness
12	Intervening only if necesssary and appropriate
13	Being patient, not hurrying
14	Using low technology approaches when possible
15	Drawing on a wide range of resource to tailor a woman's care
16	Considering all options when considering a clinical management
17	Drawing on natural resources when assisting the woman , such As ambulation, nutrition
18 -	Personalizing care
25-	Adopting a wholistic approach to the care of the woman

Vigilance and attention to details :

1-	Being vigilant and paying attention to details
2-	Documenting care very well
3-	Doing thorough and on-going assessments
4-	Following up on care

5- **Working to prevent problems**

6- **Practicing within a circle of safety**

7- **Consulting and referring appropriately**

8- **Being timely in clinical actions**

9- **Remaining alert to a changing clinical picture**

10- **Being adept at listening to one's own intuition when responding to the woman's changing needs**

Caring :

Respect the uniqueness of the woman:

22- **Respecting the woman and her family, understanding the family's primary importance tot he woman's support**

23- **Maintaining confidentiality, keeping from discussing cases publicly and carelessly**

24- **Avoid routinizing care, adapting to the woman's cultural and emotional needs**

26 **Involving the whole family and significant others in her care, Much as she needs**

29- **Providing thorough education and accurate information based on the woman's needs**

31 **Listening carefully to the woman's voice and responding Appropriately**

32- **Working as a partner with the woman**

33-	**Helping the woman draw on her own inner strenght**
34-	**Advocating for the woman's needs**
35-	**Being gentle with the woman when needing to do uncomfortable procedures**

Respecting the woman through the setting:

19-	**Maintaining a supportive presence in labor staying with the woman , as she desires**
20-	**Providing positive encouragement and validation**
21-	**Creating an environment that is respectful, even under often dismal external circumstances**
27	**Being accessible and available to the woman**
28	**Making an effort to provide adequate time to the woman's needs**
30	**Obtaining informed consent**

Professional

36-	**Updating one's professional knowledge through journal reading and regular attendance at conferences and seminars**
37-	**Using reflection to understand and improve clinical practice**
38-	**Seeking peer review mechanisms to enhance the quality of clinical practice**
39	Bringing balance to personal and professional life

Appendix F

Delphi Score for Each Dimension

Table 3.3

Delphi Study Score For Each Dimension

Delphi study statement	Rank	Derived Question
1-Supports the normal process of birth	6.95	11- Supporting the normal process of birth as a healthy physiologic event, not an illness
2- Maintains confidentiality	6.89	23- Maintaining confidentiality, keeping from discussing cases publicly and/or carelessly
3- Respects the woman and her family	6.80	22- Respecting the woman and her family, understanding the family'' primary importance to the woman's support
4- Thorough and on-going assessment	6.80	3- Doing thorough and ongoing assessments
5- Create an setting/environment that is respectful, and reflective of the woman's needs	6.75	21-Creating an environment that is respectful, even under often dismal external circumstances
6- Practices within a circle of safety	6.74	6- Practices within a circle of safety
7- Listen carefully & responds	6.73	31- Listening to the woman's voice

appropriately		and responding appropriately
8-Continually update own knowledge	6.73	36-Updating one's own professional knowledge through journal reading and regular attendance at conferences and seminars
9- Intervenes in birth process only if appropriate	6.69	12-Intervening only if necessary and appropriate
10-Helps women to draw upon her inner strength	6.69	33- Helping the woman draw upon her inner strength
11-Provides thorough education and accurate information based on the women's needs	6.67	29-Providing thorough education and and accurate information based on the woman's needs
12-Personalizes care	6.67	18- Personalizing care , avoiding a one-fit-all approach
13-Considers the whole woman	6.64	25-Adopting a holistic approach to care of the woman
14-Follow up on care	6.62	4- Follows up on care
15- Provides positive encouragement and validation	6.61	20- Providing positive encouragement and validation
16-Consults and refers appropriately	6.59	7- Consulting and referring appropriately
17-Advocate with women's needs	6.57	34- Advocating for the woman's needs

18-Timely in clinical action	6.55	8- Being timely in clinical actions
19-Considers cultural background	6.51	-Integrated in #24
20-Personal introspection of practice	6.49	37- Using reflection to understand and improve clinical practice
21-Works to prevent problems	6.41	5-Working to prevent problems
22-Draws upon natural resources to assist women such as rest,nurturing &nutrition	6.44	17- Draw on natural resources when assisting women such as nutrition, ambulation
23- Gentleness	6.42	35- Being gentle with the woman when needing to do uncomfortable procedures
24-Vigilance and attention to details	6.41	1- Being vigilant and paying attention to details
25-Avoids routinization of care	6.40	24- Avoid routinization of care adapting to the woman's cultural and emotional needs
26- Maintains supportive presence	6.38	19- Maintaining a supportive presence in labor, staying with the woman as she desires
27- Considers all options when providing care	6.35	16- Considering all options when deciding on clinical management

28- Utilizes a wide range of resources to assist the woman	6.34	15- Drawing on a wide range of resources to tailor to the woman's needs
29-Uses intuition	6.31	10- Being adept at listening to one's own intuition when responding towoman's changing needs
30-Remains alert	6.31	9- Remaining alert to a changing clinical picture
31- Maintaining appropriate eye contact	6.29	--------not used. --Impossible for a student to observe ----------
32-Obtained informed consent	6.29	30- Obtaining informed consent
33-Works as a partner with the woman	6.29	32- Working as a partner with the woman
34-Involves family in care	6.27	26- Involves the whole family and significant others in her care, as much as she wishes
35-Accessible or available to woman	6.22	27- Being accessible and available to the woman
36-Patient, does not hurry	6.22	13- Being patient, not hurrying
37-Uses low technology approach to birth when appropriate	6.21	14- Using low technology approaches when possible
38-Tries to provide adequate time to	6.12	28- Making an effort to make adequate

meet the woman's needs		**time to the woman's needs**
39-Balances professional/personal life	**6.12**	**39-Bringing balance to personal and professional life**
40-Documents care well	**6.10**	**2-Documenting care very well**
41-Peer review of practice	**6.04**	**38- Seeking peer review mechanisms to enhance the quality of clinical practice**

Appendix G

Ranking of all 39 Actual Dimensions by Frequency of High Emphasis

Ranking of the Actual emphasis using the Highest (6-7) Paired Responses on all 39 Dimensions

Rank	Dimension #	Dimension
1	35	Caring: Respect the uniqueness of the woman: Being gentle with the woman when needing to do uncomfortable procedures.

Discussion: Sixty eight respondents gave a value of 6 to this dimension, while one hundred and thirty five gave it a full 7, for a total of two hundred and three, or 82.9% of all respondents having observed high emphasis on this particular dimension. Only 1.6% reported little or no emphasis on the observation of this dimension .The overall mean was 6.30, granting this observed dimension first rank as observed with the highest emphasis. On the ideal scale, two hundred and thirty seven, or 96.7% of respondents gave a high emphasis placing this dimension on the 4^{th} position.

Rank	Dimension #	Dimension
2	9	Therapeutic: Vigilance and attention to details :Being alert to a changing clinical picture.

Discussion: Ninety six new midwives gave a 6 to this dimension, and ninety five gave it a 7, resulting in one hundred and ninety one or 78% having observed a high

emphasis on this dimension. One value was missing, resulting in N=244. Eight percent of the respondents observed little or no emphasis on this dimension . the overall mean for the sample was 6.10. The Ideal response to this same dimension received high emphasis by 95.6% of respondents, ranking sixth on the Ideal scale.

Rank	Dimension #	Dimension
3	7	Therapeutic: Vigilance and attention to details: Consulting and referring appropriately

Discussion: One hundred and eighty five (75.5%) respondents gave a high emphasis to the observation of this dimension during their clinical experience. Seventy nine answered 6, and one hundred and six a 7. There were two missing values. Only 2% observed less than 3 for little or no emphasis, and the overall mean was 6.09. The Ideal expression from the same respondents ranked this dimension 21st , as the Ideal reflection of exemplary midwifery, with 93.4% assigning a high emphasis: Fifty two assigned a 6, one hundred and seventy seven chose a 7.

Rank	Dimension #	Dimension
3	21	Caring: Respect the woman through the setting: Creating an environment that is respectful, even under often dismal external circumstances

Discussion: This dimension ties with the previous one for rank 3.The same number, namely one hundred and eighty five (75.5%) observed a high emphasis. There were also two values missing. The same seventy nine was given for 6, and one hundred and six for 7. Little or no emphasis was observed by 2.8% of the respondents, and the overall mean was a lower than the preceding dimension by .03, at 6.06. The

Ideal, however, was ranked also third, at 96.8% of respondents giving a degree of 6 and 7.

Rank	Dimension #	Dimension
5	22	Caring: Respecting the uniqueness of the woman: Respecting the woman and her family, understanding the family's primary importance to the woman's support

Discussion: Seventy nine midwives answered a 6, and one hundred and six a 7 , for a total of one hundred and eighty five or 75.1%, ranking this dimension 5th on the Actual scale of observed exemplary midwifery. The respondents observed little or no emphasis on this dimension in 3.7% of the total sample. The overall mean for this Actual dimension was 6.03. The Ideal response of 95.1% tied the rank 9th with the 6th dimension , Practicing within a circle of safety on the ideal perception .

Rank	Dimension#	Dimension
6	20	Caring: Respecting the woman through the setting: Providing positive encouragement and validation

Discussion: Sixty eight respondents answered a 6, one hundred and fourteen a 7 , for a total of 182 or 73.8% , placing this dimension 6th for all dimensions of Actual observations of exemplary midwifery process. The respondents observed no

emphasis on this dimension in 4.8% of the sample, and the overall mean was 6.02. The Ideal ranked 5th at 95.9%, which is very close to the Actual observation

Rank	Dimensions #	Dimension
7	6	Therapeutic: Vigilance and attention to details: Practicing within a circle of safety

Discussion: Seventy three respondents answered a 6 on the scale, and 101 gave it the full emphasis of 7 for a total of 174, or 71% of all participants. There was one missing value. The participants observed little or no emphasis in 3.2% of the sample, and the overal mean was 5.95. The Ideal emphasis greater or equal to 6 was answered by 95.1% of the participating graduates, ranking this dimension 9th in importance of exemplary midwifery

Rank	Dimension #	Dimension
8	23	Caring: Respect the uniqueness of the woman: Maintaining confidentiality, keeping from discussing cases publicly and/or carelessly

Discussion : Fifty five new grads answered a 6 on the scale of Actual emphasis, and 114 gave it a 7, for a total of 169, or 68.9% of the total Actual response. The respondents, however, observed no , or little emphasis in 6.5% of the sample with an overall mean of 5.31. On the Ideal perception, 97.2% ranked it higher or equal to 6 in emphasis, for a second place in importance for exemplary midwifery process.

Rank	Dimension #	Dimension
9	30	Caring: respecting the woman through the

setting: Obtaining informed consent

Discussion : Three values were missing from the total pool of respondents. Of the 242 participants, 46 choose an emphasis of 6, and 117 chose 7, for a total of 163, or 66.6%, placing this dimension 9th in the rank of observed emphasis .Participants observed little or no emphasis on thid dimension of confidentiality in 8.2% of the sample, and the overall mean was 5.83. The Ideal perception of this dimension was answered by 94.3% of the respondents on a value of 6 or 7, placing it 13, in a tie with 3 others, Dimension 1, Vigilance and attention to details, dimension 3, doing on-going assessments and dimension 36, Updating one's professional knowledge.

Rank	Dimension #	Dimension
10	3	Therapeutic: Vigilance and attention to details: Doing thorough and on-going assessments

Discussion: Eighty eight respondents observed an emphasis of 6, and 72 of 7, resulting in a total of 160, or 65.3% . No emphasis was reported by 2.95 of respondents, with a final overal mean of 5.80. The Ideal perception on the emphasis of this dimension was 94.3%, 14th, on par with the previous ranking dimension #30, of Obtaining informed consent, dimension #1, Being vigilant, and dimension 36, Updating one's professional knowledge.

Rank	Dimension #	Dimension
11	8	Therapeutic: Vigilance and attention to details: Being timely in clinical actions.

Discussion: **There was one value missing from the total respondent pool, for a total of 244. Seventy nine respondents answered a 6, 76 respondents a 7, totaling 155, or 63.2 %. Little or no emphasis was reported by 3.6% of participants, and the overall mean was 5.76. The Ideal perception of this same dimension was 89.8% for values greater or equal to 6 on the scale. The Ideal perception of the dimension # 8 ranked 31 on a total of 39.**

Rank	Dimension #	Dimension
12	1	Therapeutic: Vigilance and attention to details :Being vigilant and paying attention to details

Discussion: **Eighty three respondents chose a 6 and seventy one respondents chose a 7 on the scale of Emphasis for the Actual observation, for a total of 154, or 62.9% .Little or no emphasis was reported by 1.2% of respondents, and the mean was 5.76. The Ideal perception , at 94.3% was ranked 13th, again sharing with dimension #3, #30, #36 (see above)**

Rank	Dimension #	Dimension
13	27	Caring: Respect the woman through the setting: Being available and accessible to the woman

Discussion: **Three values were missing from this pool, resulting in a sample of 242. Seventy one new grads answered a 6, and seventy nine a 7 for a total of 150 or 61.2% of respondents assigning a high emphasis on the observation of this**

dimension during their clinical experience. Respondents observed little or no emphasis in 6.5% of the sample. The overall mean was 5.69. Ideally, the respondents ranked this dimension 25th, at 92.2%, for their perception of exemplary midwifery.

Rank	Dimension #	Dimension
14	34	Caring: respect the woman through the setting: Advocating for the woman's needs

Discussion : Sixty six respondents answered a 6, eighty one respondents a 7, totaling 147 participants observing high emphasis, or 60% of the sample, ranking 14th for all dimensions.Less or equal to 3 on the scale was observed by 6.1%. The overall mean was 5.66. On the Ideal perception , 94.7% , (ranking 11th) of the respondents perceived this caring process as expressing exemplary midwifery.

Rank	Dimension #	Dimension
15	26	Caring: Respect the uniqueness of the woman: Involves the whole family and significant others in her care, as much as she wishes

Discussion: Two values were missing from the respondents.(N=243) A total of 145 participants, 59.2% assigned a high emphasis (68 for 6, 77 for 7) to this dimension of Actual exemplary midwifery observation ranking it 15th on the scale of 1 to 39 . Low and no emphasis was observed by 8.1% of the sample. The overall mean was 5.63. The Ideal perception of the same dimension ranked 19th, with a 93.5% high emphasis

Rank	Dimension #	Dimension
16	31	Caring: Respect the uniqueness of the woman: Listening carefully to the woman's voice and responding appropriately.

Discussion : Sixty nine observed an emphasis of 6, 71 observed a 7 totaling 140, 57.2% ranking 16th for all Actual dimensions of exemplary midwifery process. The respondents observed little or no emphasis in 6.5% of the sample, and the overall mean was 5.60. Ideal perception of 92.2% ranked 25th.

Rank	Dimension #	Dimension
17	4	Therapeutic: Vigilance and attention to details :Following up on care

Discussion: One value was missing, resulting in N=244.Seventy new midwives responded with a 6, and 55 with a 7, reaching a total of 125, 51% for high emphasis on this dimension of Therapeutic exemplary midwifery process, ranking 16th.Low or no emphasis, however, was observed by 11.4% of the sample. The overall mean was 5.32. Ideally, 93% of the new midwives perceived that this dimension should receive high emphasis in exemplary midwifery process, ranking at 22nd.

Rank	Dimension #	Dimension
18	32	Therapeutic: Respect the uniqueness of the woman: Working as a partner with the woman

Discussion: **Sixty one respondents assigned a 6 and 77 assigned a 7 on the ' emphasis of observed Actual exemplary process", for a total of 138, or 56.3%. The respondents observed low or no emphasis in 7.7% of the sample. The mean was 5.58. The Ideal perception of respondents for this same dimension was 91.4% and ranked 27th., together with diemsnsion 5, Working to prevent problems.**

Rank	Dimension #	Dimension
18	36	Professional Issue: Updating one's own knowledge through journal reading and regular attendance at conferences and seminars

Discussion: **Sixty three of the respondents gave a 6 and 75 gave a 7 for a total of 138 or 56.3% for this dimension of Actual midwifery process, tying the rank with the previous dimension #32. The overall mean was 5.54, with low or no emphasis observed by 8.9% of participants. Ideally, the respondents perceived this aspect of professional issue to be ranked 13th at 94.3%, together with dimension #1, #3 and #32.**

Rank	Dimension #	Dimension
20	29	Therapeutic: Respect the woman through the setting: Providing thorough education and accurate information based on the woman's needs.

Discussion: Two values were missing from the sample pool. One hundred and thirty four respondents, 54.7% (64 for answering 6, 70 answering 7) ranked this dimension of Caring a 20th on the scale of 1 to 39 for all dimensions of Actual exemplary midwifery observed . Respondents observed little or no emphasis in 7.3%, and the mean was 5.56. Ideally, the new midwives perceived this dimension as 93.9% reflective of exemplary midwifery, at a rank of 17th tying with #17, Drawing on natural resources when assisting the woman.

Rank	Dimension #	Dimension
21	11	Therapeutic: Supporting the normal process: Supporting the normal process of birth as a healthy physiological event not as an illness

Discussion: Fifty new midwives answered a 6 for high emphasis and 83 a 7. The total of 133 represented 54.3%, ranking 21st for 39 dimensions .Low and no emphasis was observed by 11.4% of respondents, and the mean was 5.45. The Ideal perception ranked first at 98.3% of respondents assigning this dimension a high emphasis in their perception of exemplary midwifery.

Rank	Dimension #	Dimension
22	17	Therapeutic: support the normal process: Drawing on natural resources when assisting the woman, such as ambulation, nutrition

Discussion: One hundred and twenty five, or 51% of respondents, (52 answering a 6, 73 a 7) reported observing a high emphasis on these modalities during their integration and ranked it at 22nd. However, 15% reported observing an emphasis of equal or less thana 3. The mean for this Actual dimension was 5.25. Ideally, those new midwives perceived this dimension as 93.9% in importance for exemplary midwifery, ranking it 17th, together with dimension #29, Providing education.

Rank	Dimension #	Dimension
23	10	Therapeutic: Vigilance and attention to details: Being adept at listening to one's own intuition when responding to the woman's changing needs.

Discussion : 50.6%, or 124 respondents gave high emphasis (6=72, 7=52) to the observation of this dimension during their last clinical experience, ranking it 23rd. Eleven percent observed low or no emphasis. The mean was 5.33. Their Ideal perception was 84.9%.on high emphasis, a ranking of 31st for 39 dimensions.

Ranking	Dimension#	Dimension
23	28	Caring: Respect the woman through the setting : Making an effort to provide adequate time to the woman's needs.

Discussion: This Dimension of exemplary midwifery had 3 missing values, resulting in a N=242. It tied with the previous dimension #10 for the 23rd rank, with 50.6% of

the respondents assigning a value of greater or equal to 6, namely 124. Seventy four answered a 6, fifty a 7. Low or no emphasis was observed by 10.1% and the overall mean was 5.37. Ideally, the respondents ranked this dimension 29th , (90.6%) together with dimension #33: Helping to draw inner strength.

Rank	Dimension #	Dimension
25	24	Caring: Respecting the uniqueness of the woman: Avoiding routinizing care, adapting to the woman's cultural and emotional needs

Discussion: Sixty eight of the respondents chose a 6, and 54 a 7 giving a total of 122 or 49.8% to the observed emphasis on this dimension of exemplary midwifery process. Ten percent of respondents observed little or no emphasis on this dimension. The overall mean was 5.31. The Ideal ranking 23rd, at 92.6% represented the Ideal perception of exemplary midwifery by new graduates of midwifery programs.

Rank	Dimension #	Dimension
26	2	Therapeutic: Vigilance and attention to details: Documenting care very well.

Discussion : Sixty respondents answered a 6, and the same for a seven, total 120 or 49% ranking a 26th.The participants observed little or no emphasis in 10.25 of the sample. The overall mean was 5.73. The Ideal perception of exemplary midwifery was 92.3% was ranked at 24th.

Rank	Dimension#	Dimension
26	18	Therapeutic: Support the normal process of birth: Personalizing care, avoiding a one–fit–all approach.

Discussion : This Actual dimension tied the rank with the previous one , at 49% of the sample choosing a 6(60 respondents) or 7(60 respondents), as emphasis observed during their clinical rotation. Litle or no emphasis was observed by 10.2 % of the respondents. The mean was 5.30. The Ideal perception for this dimension was ranked 8th or 95.2% for that same graduating student sample.

Rank	Dimension #	Dimension
28	5	Therapeutic: Vigilance and attention to details: Working to prevent problems.

Discussion : Sixty seven respondents answered a 6 and 50 answered a 7 giving this Actual dimension of exemplary midwifery process a 47.7% response for high emphasis from sample ,and a rank of 28th. Low or no emphasis was observed by 9.3% of respondents. the overall mean was 5.36. The Ideal perception of this dimension is ranked 27th, at 91.4%. Four values were missing from the sample.

Rank	Dimension#	Dimension
29	16	Therapeutic: Support the normal process of birth: Considering all options when

deciding on a clinical management

Discussion: Eighty respondents assigned a 6 and 36 a 7 for a total of 116 (47.4%) for the observation of high emphasis on this Actual dimension of exemplary midwifery process, ranking it at 29th. Low or no emphasis was observed by 8.1% of participants. The mean was 5.27. The Ideal counterpart on the perceived emphasis on exemplary midwifery was 95.5%., ranking a 7th on 39 dimensions.

Rank	Dimension #	Dimension
30	33	Caring: Respect the uniqueness of the woman: Helping the woman draw on her inner strength.

Discussion: One value was missing . Sixty respondents assigned this dimension a 6 and fifty three a 7 for a total of 113, or 46.1% for observation of high emphasis on this dimension of exemplary midwifery process. Low or no emphasis was observed by 9.8%. the mean was 5.67. The Ideal perception of this dimension ranked 29th (90.6% high emphasis by respondents) tied with dimension # 28, Providing adequate time to meet the woman's needs.

Rank	Dimension #	Dimension
31	19	Caring: Respect the woman through the setting: Maintaining a supportive presence

presence in labor staying with the woman as she desires

Discussion : Forty five new midwives answered a 6 and sixty one a 7 for a total of 106, or 43.3% on high emphasis for this sample, ranking it at 31st.No emphasis , or a low emphasis was observed by 18.4% of the respondents. The overall mean was 5.05. The Ideal perception of this exemplary dimension was ranked 11th at 94.7% tied with dimension #34, Advocating for the woman's needs.

Rank	Dimension #	Dimension
32	12	Therapeutic: Support the normal process: Intervening only if necessary and Appropriate

Discussion: Forty three respondents answered a 6 and 51 a 7 for a total of 94 or 38.4% of observed high emphasis during Integration, ranking it at 32nd for 39 potential dimensions. Low or no emphasis was observed by 16%, and the overall mean was 4.97. The Ideal, at 93.5% ranked at 19th, sharing a position with dimension # 26, Involving the whole family in the care.

Rank	Dimension #	Dimension
33	37	Professional Issues: Using reflection to understand and improve clinical practice

Discussion: There were 5 missing values from the sample resulting in 240 respondents, who assigned 52 values of 6, and 42 values of 7, for a total of 94, or 38.3% for the observation of high emphasis for this dimension, ranking 33rd. No emphasis was observed by 15.5% of respondents. The mean was 5.02. The Ideal perception was ranked 36th by the respondents. (84.95 high emphasis)

Rank	Dimension #	Dimension
34	25	Therapeutic: Support the normal process: Adopting a wholistic approach to the care of the woman.

Discussion : Two values were missing. (N=243) Fifty six respondents chose a 6 and thirty six a 7 on the high emphasis scale for this dimension of observed exemplary midwifery, resulting in a total of 92, or 37.6% high emphasis observation. Low or no emphasis was reported by 12.3% of respondents. The mean was 5.00. The Ideal perception of this exemplary dimension ranked at 32nd, with 89.4% of respondents answering a high emphasis on this dimension of exemplary midwifery process

Rank	Dimension #	Dimension
34	38	Professional Issue: Seeking peer-review mechanism to enhance the quality of clinical practice

Discussion: Three values were missing. Forty eight respondents answered a 6, and forty four a 7 for a total of 92, or 37.6% , a rank of 34, same as dimension 37 above, for the observation of high emphasis on this dimension of exemplary midwifery

process. The participants reported low or no emphasis in 25.2% of the sample, slighly over one quarter of the entire sample. The mean was 5.02. The Ideal ranked at 36th, also tying in with dimension #10, Listening to one's intuition, and dimension # 37, Using reflection in practice.

Rank	Dimension#	Dimension
36	14	Therapeutic: Support the normal process : Using low technology approach when Possible

Discussion: Forty four new midwives chose a 6for high emphasis and 35 chose a 7 totaling 79, or 32.3% , ranking this dimension of exemplary midwifery practice 36th.Low or no emphasis reported by 18.3. The mean was 4.81. The Ideal perception of this same dimension was chosen by 89.4% of the sample, as reflecting exemplary midwifery , ranking 32nd, with dimension #39, Balanced life, and dimension #25,Adopting a wholistic approach. .

Rank	Dimension #	Dimension
37	13	Therapeutic: Support the normal process: Being patient, not hurrying.

Discussion : Seventy eight respondents answered a value greater or equal to 6 (41 for 6, 37 for 7) for a percentage of 32.3%, ranking 37th for the 39 dimensions of Actual observation of exemplary midwifery process. Graduating students observed little or no emphasis in 16.75 of sample. The mean was 4.86. The Ideal dimension of

perceived high emphasis for exemplary midwifery process ranked at 35th assigned high emphasis by 86.9% of respondents.

Rank	Dimension#	Dimension
38-39	15	Therapeutic: Support the normal process: Drawing on a wide range of resources to tailor a woman's needs.

Discussion : Forty respondents assigned a 6, and thirty three a 7 for a total of 73, 29.8% for high emphasis on this observed dimension of exemplary midwifery process , tying the rank with dimension # 39, Having a balanced life.Low or no emphasis observed in 16.3% or sample. The mean was 4.85. The Ideal perception of respondents for this dimension was 84.5%, ranking 39th.

Rank	Dimension#	Dimension
38-39	39	Professional Issue: Bringing balance to personal and professional life

Discussion: Thirty six of the respondents answered a 6 , and 37 answered a 7 for a total of 73, 29.8%, tying in rank with dimension #15, Drawing on a wide range of resources and placing these last two dimensions last on the scale for the 39 dimensions. Over one third of respondents observed no emphasis on this dimension, making it the highest ranking no emphasis observed. The overall mean was 4.32. Ideal counterpart for dimension 39, ranked 32nd, together with dimension # 14 , Using low technology, and dimension # 25, Adopting a wholistic approach.

Appendix H

Ranking of all 39 dimension by the difference between Ideal and Actual

Ranking of the 39 Dimensions by difference between Ideal and Actual

Rank	Dimension #	Dimension
1	35	Caring: Respect the uniqueness of the woman: Being gentle with the woman when needing to do uncomfortable procedures

Discussion: The difference between the Ideal mean of 6.79 and Actual 6.30 is .49 ranking this dimension first in congruence between Ideal perception and Actual observation of exemplary midwifery process. Differences on High emphasis for scales 6 and 7 was 13.8%, and the difference between the highest emphasis of 7 for both Ideal and Actual is 29.4%..

Rank	Dimension #	Dimension
2	7	Therapeutic: Vigilance and attention to details: Consulting and referring appropriately.

Discussion: The difference of .56 between the Ideal mean of 6.65 and Actual of 6.09 rank this dimension of exemplary midwifery second on the scale of 1 to 39 for all dimensions. Differences in high emphasis of 6 and 7 was 17.9%, and the difference between the frequency for the highest emphasis of 7 was 28.95.

Rank	Dimension #	Dimension
3	9	Therapeutic: Vigilance and attention to details: Remaining alert to a changing clinical picture

Discussion: The difference of .64 between the Ideal mean of 6.74 and the Actual of 6.10 places this dimension of exemplary midwifery process third in congruence for all 39 dimensions. The difference between Ideal and Actual of the emphasis of 6 and

7 was 17.6% and the difference between ideal and Actual for the highest emphasis of 7 was 38.8%.

Rank	Dimension #	Dimension
4	20	Caring: Respecting the woman through the setting: Providing positive encouragement and validation

Discussion: The difference or .72 between the Ideal mean of 6.74 and the Actual mean of 6.02 places this dimension of exemplary midwifery process 4th in congruence between The Ideal perception of students and the Actual observation of the process for all dimensions. The difference between high emphasis 6 and 7 between Ideal and actual is 22.1%, and the difference between the highest emphasis of 7 is 32.7%

Rank	Dimension #	Dimension
4 (tied with above)	22	Caring: Respect the uniqueness of the woman: Respect the woman and her family, understanding the family's primary importance to the woman's support.

Discussion: The difference of .72 ties this dimension of exemplary practice with dimension #20, for a 4th place in the level of congruence achieve on the practice of exemplary midwifery process. The mean for Ideal was 6.74, and the mean for Actual was 6.03. The difference between high emphasis 6 and 7 between Ideal perception

and Actual observation is 20, and the difference between the values of the highest emphasis (7) is 36.3.

Rank	Dimension #	Dimension
6	21	Caring : Respect the woman through the setting: Creating an environment that is respectful, even under often dismal external circumstances .

Discussion: The difference of .73 between the mean of Ideal perception of exemplary midwifery, 6.79, and the Actual observation's mean of 6.06 , ranking this dimension 6th in congruence between Ideal perception and Actual observation. The difference between the high emphasis of 6 and 7 between Ideal and Actual is 21.3%, and the difference for the highest emphasis is 40.4%

Rank	Dimension #	Dimension
7	8	Therapeutic: Vigilance and attention to details: Being timely in clinical action.

Discussion: The difference of .77 between the mean of Ideal perception of exemplary midwifery overall mean of 6.53 and the Actual observation in clinical practice's overal mean of 5.76 ranks this dimension 7th on the scale of congruence for all 39 dimensions. The difference between the frequencies for high emphasis of 6 and 7 is 26.6% and the difference between the frequency if the highest emphasis of 7 is 32.7%.

Rank	Dimension #	Dimension

8	6	Therapeutic: Vigilance and attention to details: Practicing within a circle of safety

Discussion: The difference of .79 between the mean of Ideal perception , 6.74 and Actual observation of this dimension, 5.95 ranks this dimension 8th for congruence between Ideal and Actual on all 39 dimensions of exemplary midwifery process. The difference between the frequencies of high emphasis (6 and 7)is 24.1% and the difference between the responses to the highest emphasis is 36.8%.

Rank	Dimension #	Dimension
9	30	Caring: Respect the woman through the setting: Obtaining informed consent

Discussion: The difference of .82 between the mean 6.65 for Ideal perception and 5.83 for Actual observation ranks this dimension 9th in congruence. The difference between the high emphasis of 6 and 7 is 27.7%, and the difference in the frequency for the highest emphasis of 7 is 22.8%.

Rank	Dimension #	Dimension
10	3	Therapeutic; Vigilance and attention to details: Doing thorough and on-going assessments

Discussion : The difference of .85 for the mean of Ideal perception (6.64) and Actual observation (5.80) ranks this dimension 10th in level of congruence. The difference between the frequency for high emphasis 6 and 7 is 29% and that of the highest emphasis (7) is 41.2%.

Rank	Dimension #	Dimension
11	1	Therapeutic: Vigilance and attention to details;

Being vigilant and paying attention to details.

Discussion: The difference between the mean for Ideal perception of 6.62 and Actual observation of 5.76 is of .87, ranking this dimension 11th on the congruence scale for all 39 dimension. The difference between high emphasis for Ideal and Actual is set at 31.4% , while the difference between the frequency for the highest emphasis of 7 is 40.8% for all respondents.

Rank	Dimension #	Dimension
12	23	Caring: Respect the uniqueness of the woman: Maintaining confidentiality, keeping from discussing cases publicly and/or carelessly

Discussion: The difference of .89 between the means of Ideal perception of exemplary midwifery process , 6.78 and Actual observation 5.90,ranks this dimension 12th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 28.3%, and the difference between the frequency of Ideal highest emphasis and Actual is 36.8%.

Rank	Dimension #	Dimension
13	2	Therapeutic: Vigilance and attention to details: Documenting care very well.

Discussion: The difference of .90 between the mean for Ideal perception of exemplary midwifery by respondents (6.63) and the mean of the Actual observation of exemplary midwifery (5.73) ranks this dimension 13th for all respondents. The difference between the high emphasis of 6 and 7 from Ideal and Actual is 43.3%, and the difference between the highest emphasis is 48.2%.

Rank	Dimension #	Dimension
14	27	Caring: Respect the woman through the setting: Being accessible and available to the woman

Discussion: The difference of .93 between the Ideal perception 's mean , 6.63 , and the Actual observation 's mean 5.69 ranks this dimension 14th for congruence. . The difference between the frequency for high emphasis 6 and 7 is 31%, and the difference between the Ideal and actual for the highest emphasis 7 is 39.2%

Rank	Dimension #	Dimension
15	26	Caring: Respect the uniqueness of the woman: Involves the whole family and significant others in her care , as much as she wishes .

Discussion : The difference of .98 from the Ideal mean of perception (6.61)and the Actual mean for observation (5.63) ranks this dimension 15th on the scale of congruence for all 39 dimensions. The difference between high emphasis of 6 and 7 of Ideal and Actual is 34.3%, and the difference between the Ideal and the Actual for the highest emphasis of 7 is 36.4%

Rank	Dimension #	Dimension
16	31	Caring: Respect the uniqueness of the woman: Listening carefully to the woman's voice and

responding appropriately

Discussion: The difference of 1.0 between the ideal mean of 6.59 and the Actual mean of 5.60 ranks this dimension 16th for congruence on all 39 dimensions. The difference between the frequency of Ideal and Actual high emphasis of 6 and 7 is 35% and the difference between the Ideal and Actual frequency for the highest emphasis of 7 is 48.1%

Rank	Dimension #	Dimension
17	32	Caring: Respect the uniqueness of the woman: Working as a partner with the woman.

Discussion: The difference of 1.05 between the mean for Ideal perception of exemplary midwifery by respondents (6.62) and the mean of the Actual observation of exemplary midwifery (5.58) ranks this dimension 17th for all respondents. The difference between the high emphasis of 6 and 7 from Ideal and Actual is 35.1%, and the difference between the highest emphasis is 39.6.

Rank	Dimension #	Dimension
17	34	Caring: Respect the uniqueness of the woman: Advocating for the woman's needs.

Discussion: The difference of 1.05 ties this dimension of exemplary practice with dimension #32, for a 17th place in the level of congruence achieve on the practice of exemplary midwifery process. The mean for Ideal was 6.71, and the mean for Actual was 5.66. The difference between high emphasis 6 and 7 between Ideal perception

and Actual observation is 34.7%, and the difference between the values of the highest emphasis (7) is 44.5%. .

Rank	Dimension #	Dimension
19	10	Therapeutic: Vigilance and attention to details: Being adept at listening to one's own intuition when responding to the woman's changing needs

Discussion: The difference of 1.12 from the Ideal mean of perception (6.45)and the Actual mean for observation (5.33) ranks this dimension 19th on the scale of congruence for all 39 dimensions. The difference between high emphasis of 6 and 7 of Ideal and Actual is 34.3%, and the difference between the Ideal and the Actual for the highest emphasis of 7 is 41.7% .

Rank	Dimension #	Dimension
19	36	Professional Issue: Update one's own professional knowledge through journal reading, and regular attendance at conferences and seminars.

Discussion : The difference of 1.12 ties this dimension of exemplary practice with dimension #10, for a 19th place in the level of congruence achieve on the practice of exemplary midwifery process. The mean for Ideal was 6.66, and the mean for Actual was 5.54. The difference between high emphasis 6 and 7 between Ideal perception

and Actual observation is 38%, and the difference between the values of the highest emphasis (7) is 47.7%.

Rank	Dimension #	Dimension
21	29	Caring: Respect the uniqueness of the woman: Provide thorough education and accurate information based on the woman's needs.

Discussion : The difference of 1.18 from the Ideal mean of perception (6.74)and the Actual mean for observation (5.56) ranks this dimension 21st on the scale of congruence for all 39 dimensions. The difference between high emphasis of 6 and 7 of Ideal and Actual is 39.2%, and the difference between the Ideal and the Actual for the highest emphasis of 7 is 50.6% .

Rank	Dimension #	Dimension
22	5	Therapeutic: Vigilance and attention to details: Working to prevent problems

Discussion: The difference of 1.23 between the means of Ideal perception of exemplary midwifery process 6.60 , and Actual observation 5.36 ,ranks this dimension 22nd for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 43.7 %, and the difference between the frequency of Ideal highest emphasis and Actual is 46.1 %.

Rank	Dimension #	Dimension
23	28	Caring: Respect the woman through the setting:

Making an effort to provide adequate time to the

woman's needs

Discussion: The difference of 1.27 between the means of Ideal perception of exemplary midwifery process 6.64 , and Actual observation 5.37 ,ranks this dimension 23rd for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 27.7 %, and the difference between the frequency of Ideal highest emphasis and Actual is 22.8 %.

Rank	Dimension #	Dimension
24	4	Therapeutic: Vigilance and attention to details; Follow up on care

Discussion: The difference of 1.32 between the means of Ideal perception of exemplary midwifery process , 6.65 , and Actual observation 5.32,ranks this dimension 24th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 42 %, and the difference between the frequency of Ideal highest emphasis and Actual is 49.8%.

Rank	Dimension #	Dimension
24	24	Caring: Respect the uniqueness of the woman: Avoid routinizing care: Adapting to the woman's cultural and emotional needs

Discussion: The difference of 1.32 ties this dimension of exemplary practice with dimension # 4 , for a place 24th in the level of congruence achieved on the practice

of exemplary midwifery process. The mean for Ideal was 6.63, and the mean for Actual was 5.31. The difference between high emphasis 6 and 7 between Ideal perception and Actual observation is 42.8%, and the difference between the values of the highest emphasis (7) is 50.2%.

Rank	Dimension #	Dimension
24	37	Professional Issue: Uses reflection to understand and improve clinical practice

Discussion: The difference of 1.32 between the mean for Ideal perception of exemplary midwifery by respondents (634) and the mean of the Actual observation of exemplary midwifery (5.02) ranks this dimension 24th for all respondents tying with the two previous ones . The difference between the high emphasis of 6 and 7 from Ideal and Actual is 38 %, and the difference between the highest emphasis is 47.7%.

Rank	Dimension #	Dimension
27	16	Therapeutic: Support the normal process: Considers all options when deciding on a clinical management

Discussion: The difference of 1.34 ranks this dimension of exemplary practice , for a 27th place in the level of congruence achieved on the practice of exemplary midwifery process. The mean for Ideal was 6.60 , and the mean for Actual was 5.27. The difference between high emphasis 6 and 7 between Ideal perception and Actual

observation is 48.1 %, and the difference between the values of the highest emphasis (7) is 51.8%. .

Rank	Dimension #	Dimension
28	33	Caring: Respect the uniqueness of the woman: Helping the woman draw on inner strength

Discussion: The difference of 1.37 between the means of Ideal perception of exemplary midwifery process 6.64 , and Actual observation 5.67,ranks this dimension 28th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 44.5%, and the difference between the frequency of Ideal highest emphasis and Actual is 52.3%.

Rank	Dimension #	Dimension
29	11	Therapeutic: Support the normal: Supporting the normal process of birth as a healthy physiologic event, not as an illness

Discussion: The difference of 1.39 between the means of Ideal perception of exemplary midwifery process 6.83 , and Actual observation 5.45 ,ranks this dimension 29th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 44%, and the difference between the frequency of Ideal highest emphasis and Actual is 52.6%.

Rank	Dimension #	Dimension
30	18	Therapeutic: Support the normal: Personalizing

care, avoiding a one-fit-all approach

Discussion: The difference of 1.40 between the means of Ideal perception of exemplary midwifery process 6.71 , and Actual observation 5.30 ,ranks this dimension 30th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 46.2%, and the difference between the frequency of Ideal highest emphasis and Actual is 53.1%.

Rank	Dimension #	Dimension
31	17	Therapeutic: Support the normal process : Drawing on natural resources when assisting the woman, such as ambulation, nutrition

Discussion: The difference of 1.42 between the means of Ideal perception of exemplary midwifery process 6.66 , and Actual observation 5.25 ,ranks this dimension for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 42.9 %, and the difference between the frequency of Ideal highest emphasis and Actual is 43.3%.

Rank	Dimension #	Dimension
32	15	Therapeutic: Support the normal process: Drawing on a wide range of resources to tailor a woman's needs

Discussion: **The difference of 1.54 between the means of Ideal perception of exemplary midwifery process 6.38 , and Actual observation 4.85,ranks this dimension 32nd for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 54.7%, and the difference between the frequency of Ideal highest emphasis and Actual is 44.5%.**

Rank	Dimension #	Dimension
32	25	Therapeutic: Support the normal process: Adopting a wholistic approach to the care of the woman

Discussion: **The difference of 1.54 between the means of Ideal perception of exemplary midwifery process6.54 , and Actual observation 5.00,ranks this dimension 32nd for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 51.8%, and the difference between the frequency of Ideal highest emphasis and Actual is 51%.**

Rank	Dimension #	Dimension
34	13	Therapeutic: Support the normal process of birth: Being patient, not hurrying.

Discussion: **The difference of 1.59 between the means of Ideal perception of exemplary midwifery process 6.46 , and Actual observation 4.86,ranks this dimension 34th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 55.1%, and the difference between the frequency of Ideal highest emphasis and Actual is 46.9%.**

Rank	Dimension #	Dimension
35	19	Caring: Respect the woman through the setting: Maintaining a supportive presence in labor staying with the woman as she desires.

Discussion: The difference of1.60 between the means of Ideal perception of exemplary midwifery process 6.66 , and Actual observation 5.05 ,ranks this dimension 35th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is 51.4%, and the difference between the frequency of Ideal highest emphasis and Actual is 46.5%.

Rank	Dimension #	Dimension
36	14	Therapeutic: Support the normal: Using low technology approach when possible

Discussion: The difference of 1.69 between the means of Ideal perception of exemplary midwifery process 6.51 , and Actual observation 4.81,ranks this dimension 36th for congruence for all 39 dimension. The difference between the high emphasis from Ideal perception and Actual observation is57. 1 %, and the difference between the frequency of Ideal highest emphasis and Actual is 49.4%.

Rank	Dimension #	Dimension
37	38	Professional Issue: Seeking peer-review mechanism to enhance the quality of the clinical practice

Discussion: The difference of 1.69 between the means of Ideal perception of exemplary midwifery process 6.38, and Actual observation 4.69 ,ranks this dimension 37th for congruence for all 39 dimension. The difference between the

high emphasis from Ideal perception and Actual observation is 47.3 %, and the difference between the frequency of Ideal highest emphasis and Actual is39.6 %.

Rank	Dimension #	Dimension
38	12	Therapeutic: Support the normal : Intervening only if necessary and appropriate

Discussion: The difference of 1.74 ranks this dimension 38th , for a place in the level of congruence achieve on the practice of exemplary midwifery process. The mean for Ideal was 6.71, and the mean for Actual was 4.97 . The difference between high emphasis 6 and 7 between Ideal perception and Actual observation is 55.1 %, and the difference between the values of the highest emphasis (7) is 58.4%.

Rank	Dimension #	Dimension
39	39	Professional Issue: Bringing balance to personal and professional life

Discussion: The difference of 2.23 ranks this dimension last in the level of congruence achieve on the practice of exemplary midwifery process. The mean for Ideal was 6.55, and the mean for Actual was 4.32. The difference between high emphasis 6 and 7 between Ideal perception and Actual observation is 59.6%, and the difference between the values of the highest emphasis (7) is 55.5 %.

Appendix I

Population

Population

As noted previously, the nurse-midwifery educational programs number 47 in the United States and Puerto Rico. All of these accredited programs lead to the nationally recognized certification exam given by independent agent, the ACNM Credentialing Council (ACC). Certification by the ACC is a pre-requisite to state licensure as a midwife in most states. Full time midwifery programs vary in length from 12 months to 3 years depending on the pre-requisites required before admission and the type of degree granted. Method of education also vary, from traditional on-site , face to face education to complete distanced-based education programs, through Web or mail communication, with limited on-site requirements. All midwifery programs require extensive numbers of supervised, precept ed clinical hours.

Traditional nurse-midwifery programs admit registered nurses with previous experience in labor & delivery. Length of labor/delivery nursing experience varies among programs. Most programs require a Bachelor of Science in Nursing (BSN) and offer a Master of Science (MS) or Master of Science in Nursing (MSN) with concentration/specialization in Nurse-midwifery as the exit degree. Some programs do not require a bachelor degree and grant a certificate in nurse-midwifery as an exit degree. All nurse-midwifery education models are reviewed and accredited by the ACNM Division of Accreditation and all graduates from these accredited programs are eligible to sit the ACNM certifying exam and apply for state licensure. Originally, all programs required students to attend the school on a full time basis, and program duration was from one year to two years.

Innovative educational models have been increasing in the United States since the 1980's. Midwifery programs have also responded to the increasing demand of applicants for more innovative routes to the profession of midwifery. Yale University was a pioneer in admitting non-nurses and granting them a Masters in nurse-midwifery after 3 years. Students completed their nursing courses and sat the nursing licensure exam after the first year of the program, then continued their course work towards their specialty are in nurse-midwifery. These programs are often called direct entry programs, providing non-nurses an opportunity to pursue an education in the specialty area of midwifery.

In 1989, Frontier Nursing Service, in conjunction with Case Western Reserve/ Frances Payne Bolton School of Nursing jointly created the Community-Based Nurse-Midwifery Education Program (CNEP), a distance education program in Nurse-Midwifery. During the orientation stay at FNS, candidates were introduced and instructed on the use of the self-taught modular materials, the computer skills and networking key to the distance-education model, to their module coordinators, and to networking with their class cohort. Professional socialization into midwifery through the new distance learning model was accomplished through an outward bound experience. The outward bound type of experience created a bonding experience that was believed to replace the loss of student community found on campus. Following the orientation and outward bound experience students returned to their home communities, where a nurse-midwife in practice had agreed to provide one-one clinical supervision. Sophisticated networks were created through web e-mails, virtual class meetings, web exchanges between the student and their module coordinator, regional coordinators who visited the community sites and acted as liasions between students and their community preceptors as well as liaison

between the student and/or preceptor and the home institution. Students meet informally in their regions to share experiences and resources. Students and faculty (both on campus and off campus) meet annually at the national ACNM Conference. This innovative model met the call for innovation in education first presented by Carnegie Institute for Higher Education and was funded, initially, through a Pew Grant. Pass rates of graduates from the program have demonstrated the model as a successful, innovative, and increasingly popular model for self-motivated students.

In the late 1990's, as more electronic options became available, and as a response to the popularity of the CNEP model, some programs initiated distance learning using computer assisted exchanges between the school and the student. Student's were able to remain in their home community for their clinical practice education with a credentialed preceptor. In 2002 several different traditional and innovative midwifery educational options exist for prospective students. Will distance learning affect nurse-midwifery socialization process? Is it possible to absorb exemplary midwifery when some faculty are at a distance? Will exemplary clinical preceptors transmit the art and espoused values to students? Until we can identify what the consensus and/or congruence of espoused theory of midwifery is and whether students are observing this theory in actual practice, we will not be able to address the other questions raised by diverse models of education.

Today, midwifery programs are described as follows:

Midwifery Programs (as of Oct 2001)

Programs	Numbers
Post-Baccalaureate Certificate	5
Graduate programs	42
Total number of programs	47

The above programs can also offer the following options :

Distance Education Options (partial)	18
Diploma or Associate degree (AD) RN to CNM Graduate option	6
BA/BS to RN to CNM-graduate program option	12

The curriculum of each accredited midwifery program is given some flexibility to encourage creativity. However, the Midwifery Core Competencies, (see addendum __), revised every 5 years to adapt to changing health care needs and climates, must be represented and addressed in the curriculum. Generally, the curriculum is divided as follows:

Pharmacology	Didactic only
Professional Issues	Didactic only
Teaching in the Health professions	Didactic only
Review of General Anatomy and Physical assessment	Didactic and Laboratory
Primary Care of Women	Didactic, laboratory and Clinical
Antepartal care, Intrapartal care, Postpartal care Neonatology:	Didactic , laboratory and clinical hours

Students receive theoretical knowledge in the form of traditional classroom delivery, seminar participation, or through some or all distance education modules. Technical skills, such as instrumentation, are first simulated in a laboratory setting; on site for traditional programs and through return-to-campus orientation and evaluation for distance programs. For both models, clinical skills are further demonstrated and observed at clinical sites by clinical preceptors. Supervised, preceptored, clinical time is required by the acceditating body. Content of theory classes are expected to be reflected and observed in real life situations, in-as-much as possible, faculty attempt to coordinate theory with practice. In most midwifery programs, each of the fields mentioned above are practiced first separately, then integrated with a capstone experience at the end of the educational program. This last clinical experience, which integrates all areas of basic Nurse-Midwifery knowledge, is aptly called "Integration", at the end of which the graduating student is expected to function independently and safely as a beginning practitioner.

At the end of "Integration", the graduated student is invited to write the ACNM Certifying examination, which is administered three times/year. In the year 2001, the exams were given on January 19th (114 successful candidates) , June 29th (233 successful candidates) and October 19th (80 successful candidates). The 114 successful students who passed their exams on January 19th represented the following Nurse-Midwifery Accredited Programs:

Name of the Program	State	Number
Region I:		
Baystate Medical Center	Massachusett	8
U. of Rhode Island	Rhode Island	1
Region II:		
University of Pennsylvania	Pennsylvania	19
State University of New York /Brooklyn	New York	1
New York Board of Midwifery	New York	3
State University of New York at Stony Brooks	New York	4
University of Puerto Rico	Puerto Rico	3

Name of the Program	State	Number
University of Medicine and Dentistry of New Jersey	New Jersey	1
Region III:		
University of Florida	Florida	5
Medical University South Carolina	South Carolina	5
Vanderbilt University	Tennessee	14
Emory	Georgia	13
Region IV:		
Georgetown	District of Columbia	10
Frontier Nursing service ,	Kentuky	12
University of Illinois , Chicago	Illinois	2
Ohio State	Ohio	2
Region V:		
University of Colorado	Colorado	4
University of Utah	Utah	2

Region VI:		
University of South California	California	1
UCSF/SFGH	California	1
Oregon Health Sciences University	Oregon	2
Total		113

The 233 successful candidates from the June 29th 2001 exam were distributed among the nurse-midwifery programs as follows;

Name of Program	State	Number
Region I:		
Boston University	Massachusett	4
Yale University	Connecticut	13
University of Rhode Island	Rhode Island	4
Region II:		
SUNY Downstate	New York	11
SUNY Stony Brook	New York	9
Institute of Midwifery	Pennsylvania	8

University of Rochester	New York	4

Name of Program	State	Number
University of Medicine &Dentistry	New Jersey	2
New York University	New York	5
University of Pennsylvania	Pennsylvania	1
Region III:		
Shenandoah University	Tennessee	3
Medical University of South Carolina	South Carolina	3
East Carolina University	North Carolina	3
University of Miami	Florida	
Region IV:		
Marquette University		4
Frontier Nursing Service	Kentucky	29
Case Western Reserve University	Ohio	4
University of Maryland	Maryland	3
Georgetown Un iversity	DC	3
University of Cincinati	Ohio	5
University of Illinois @ chicago	Illinois	5

University of Michigan	Michigan	5

Region V:

University of Missouri	Missouri	8
University of Texas @ Galveston	Texas	7
University of Texas Tech	Texas	3
University of Minnessota	Minnessota	10
University of Utah	Utah	3
University of New Mexico	New Mexico	8
University of Kansas	Kansas	3

Region VI:

Oregon Health Science	Oregon	7
University of California/SF	California	5
University of California /SFGH	California	8
University of California/SD	California	2
University of California /LA	California	10
University of Southern California	California	1
Drew University	California	2

The successful students for the October 19th 2001 examination are :

Program	State	Number
Region I:		
Boston University	Massachusett	1
Region II:		
Columbia University	New York	21
SUNY/Stony Brook	New York	4
SUNY/Downstate	New York	1
NY Board of Midwifery	New York	1
University of Medicine and Dentistry	New Jersey	1
University of Puerto Rico	Puerto Rico	2
Institute of Midwifery	Pennsylvania	9
Region III:		
Shenandoah University	Tennessee	1
Vanderbilt University	Tennessee	1
East Carolina University	NorthCarolina	1
Emory University	Georgia	1
Region IV:		
Frontier Nursing Service	Kentucky	17

Marquette University	Wisconsin	1
Ohio State University	Ohio	2
University of Marland @ Baltimore	Maryland	1
Region V:		
University of Utah	Utah	2
University of Colorado	Colorado	4
University of Texas/Galveston	Texas	1
Parkland niversity	Texas	5
University of Kansas	Kansas	1
Region VI:		
Oregon Health Sc.	Oregon	1
University of California/ San Diego	California	1
University of Southern California/San Diego	California	1
Total		80

(The above list was obtained from the ACNM Web site:http://www. accmidwife.org.)