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**BEHAVING COLLABORATIVELY AND GETTING ALONG:
A CLASSICAL GROUNDED THEORY OF
CERTIFIED NURSE MIDWIVES COLLABORATING WITH
PHYSICIANS IN U.S. HOSPITALS**

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by

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Dedication

To my Mom and Dad who taught me the importance of higher education.

To my children to demonstrate never being too old.

To my mentor and friend Carolyn A. Phillips, R.N., Ph.D.

To my mentor and friend Barney Glaser, Ph.D.

To Mac McConnell who knows why this is dedicated to him.

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**Behaving Collaboratively and Getting Along:
A Classical Grounded Theory of
Certified Nurse Midwives Collaborating
With Physicians in U.S. Hospitals**

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Susan L. Nilsen Ph.D.

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Supervisor: Carolyn A. Phillips

This dissertation is a classical grounded theory study that examines how certified nurse midwives perceive their collaborative role as they work with physicians in U.S. hospitals. The most common reason for hospitalization in the U.S. is birth and care of the newborn (Levit, Wier, Stranges, Ryan, & Elixhauser, 2009). Although the majority of women and their newborns are healthy, maternity care costs in the U.S. are staggering (Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012). Collaboration within maternity healthcare teams may positively impact healthcare economics (Downe, Finlayson, & Fleming, 2010).

Classical grounded theory methodology was used in the current study; it is a rigorous method suitable for exploring the processes of human social phenomenon (Glaser & Strauss, 1967). Classical grounded theory methodology is focused on the data which reveals the participants' *main concern*. The participants' *main concern* is

discovered using Glaser's (1978) constant comparative method. How participants resolve their *main concern* forms the basis for the *basic social process/core category* and subcategories. The links between the subcategories form the basis for the generation of substantive grounded theory.

The most important finding of the current study is the discovery of the *behaving collaboratively* basic social process. This basic social process with its subcategories of *holding, adjusting, and releasing* fits the real life experiences of certified nurse midwives who work with physicians in U.S. hospitals. Certified nurse midwives in the current study perceived *behaving collaboratively* as a problematic experience and their *main concern* as *getting along* with their physician colleagues. The certified nurse midwives were able to resolve the problematic experience of *behaving collaboratively* through the phases of the subcategories which ultimately resulted in the generation of a substantive theory of *getting along*. Substantive theories explain the *main concern* of a specific group, in a specific setting, and predict the consequences of the modifiable conditions. Although the substantive theory of *getting along* described in this dissertation relates only to the certified nurse midwives who participated in the study, *getting along* has potential for the generation of formal grounded theory.

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List of Abbreviations

UTMB	University of Texas Medical Branch
GSBS	Graduate School of Biomedical Science
TDC	Thesis and Dissertation Coordinator
CGT	Barney Glaser's Classical Grounded Theory
BSP	Barney Glaser's Basic Social Process
CCM	Barney Glaser's Constant Comparison Method
CNM	Certified Nurse Midwife
APN	Advanced Practice Nurse
ACNM	American College of Nurse Midwives
ACOG	American Congress of Obstetricians & Gynecologists
ANA	American Nurses Association

Chapter One Introduction

This dissertation was a classical grounded theory (CGT) study to examine how Certified Nurse Midwives (CNMs) perceive their collaborative role as they work with physicians in U.S. hospitals. Collaborating in healthcare has been identified as crucial to the development of high-quality, cost-effective healthcare systems (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Downe, Finlayson, & Fleming, 2010; Reiger & Lane, 2009). CNMs have a long history of contributing to cost-effective maternity healthcare. In fact, CNMs have been collaborating with physicians in hospitals to provide maternity services for more than six decades (Retrieved from: <http://www.midwife.org/History-of-ACNM>).

The focus of the current study is on the CNM's perceptions of working collaboratively with physicians in U.S. hospitals. The study used synchronous online interviews to collect data from 16 CNMs across 13 states.

The first chapter of the dissertation will describe the problem, purpose, and significance of the study. Chapter One includes a brief introduction to the current literature and concludes with an overview of the methodology and the study delimitations.

PROBLEM STATEMENT

The most common reason for hospitalization in the U.S. is birth and care of the newborn (Levit, Wier, Stranges, Ryan, & Elixhauser, 2009). Even though the majority of women and their newborns are healthy, the cost of maternity care in the U.S. is staggering (Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012).The

estimated average cost of a vaginal delivery is 15 thousand dollars: a cesarean section for the same woman is estimated to be over 50 thousand dollars. Cutting the rate of cesarean section deliveries in half would save an estimated five billion dollars annually (Retrieved from: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf). Some authors believe collaboration within the healthcare team can have a positive impact on maternity health care economics (Downe, Finlayson, & Fleming, 2010). The prospects for collaboration are evident in one author's statement: "Effective collaboration between professional groups is increasingly seen as an essential element in good quality and safe health care. This is especially important in the context of maternity care..." (Downe, Finlayson, & Fleming, 2010, p. 250). Other authors note that collaboration in healthcare is particularly complex, even though consistently defined, but in need of further studies (D'Amour, Videla, Rodriguez, & Beaulieu, 2005). The processes of collaboration have not yet been described in the literature making the findings of the current study timely and of interest to those who provide maternity healthcare services, those who make policy related to maternity healthcare services, and those who educate future healthcare providers.

The literature over the last decade is replete with definitions and concept analyses of collaboration (D'Amour, et al; Henneman, Lee, & Cohen, 1995; Miller, 1999; Kennedy & Lyndon, 2008; King, Miller, Lurie, & Choltz, 1997; Reiger, & Lane, 2009). Yet there is little or no research on how people who collaborate interact with each other or on what it means to behave collaboratively. The present study utilized the classical grounded theory methodological approach (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012) to illuminate the processes of behaving collaboratively from the perspective of CNMs.

PURPOSE STATEMENT AND RESEARCH QUESTION

The purpose of this study was to discover a basic social process (BSP) which would allow for the generation of a classical grounded theory. Specifically, the current study investigated the processes of collaboration from the perspective of CNMs who work with physicians in hospitals in the U.S. to address the research question: “How does the CNM perceive her collaborative role with physicians in U.S. hospitals?”

BACKGROUND

The literature tends to examine two broad topics related to collaboration. The first topic is the importance of collaborating in terms of healthcare economics. The second topic is the definition and characteristics of collaboration. The following discussion is reflective of the current literature.

The cost of maternity care in the U.S. is associated with increasing rates of cesarean sections, routine unnecessary interventions, and the medicalization of childbirth (Down, Finlayson, & Fleming, 2010; Keating & Fleming, 2007). National data support the cost-effectiveness of CNM care. The American College of Nurse Midwives reports CNMs have an average primary cesarean section rate of 9.9%. On the other hand births not attended by CNMs result in a 33% primary cesarean section rate. CNMs also perform a decreased number of episiotomies at an average of 3.6 % versus the national average of 25 %, use induction of labor at a lower rate, use pharmacologic interventions for pain management at a lower rate, and CNMs have lower morbidity and mortality rates (Retrieved from: <http://www.midwife.org/History-of-ACNM>; Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012; Raisler, 2000). Labor and delivery care by CNMs are is one potential solution to the rising costs of maternity healthcare because

they use fewer interventions, resulting in fewer cesarean births, shorter hospital stays, and improved chances that mothers will choose breastfeeding (Harris, Janssen, Saxelle, Carty, MacRae, & Pettersen, 2012).

The potential impact of CNMs on the costs of maternity services in the U.S. could be much greater than it is. National data from 2009 reveal that CNMs were responsible for only 11.4 % of births in the U.S. (Retrieved 11/3/2012 from: <http://www.midwife.org/CNM/CM-attended-Birth-Statistics>). Goodman (2007) notes that midwives in developed countries outside of the U.S., who are responsible for 50% - 70% of births in their countries, have better maternal/neonatal outcomes and overall lower costs for maternity care compared to the U.S., Higher rates of midwife-attended births in other developed countries may be attributed to a variety of political, economical, and cultural differences, but the maternal/neonatal outcomes and reduced costs should not be ignored.

The philosophical differences among midwives and physicians may provide a glimpse into CNMs' limited impact on the economics of maternity services in the U.S. The medical philosophy of birth is different from the midwifery philosophy of birth; physicians view birth as a potentially hazardous event, while CNMs view birth as a normal physiologic event (Kennedy & Lyndon, 2008). These two philosophies are not mutually exclusive, but are, at times, in opposition; they are compatible insofar as birth is usually normal, though sometimes it can be complicated. The opposition of the two philosophies lies in the blurry line between normal and complicated.

In addition to acknowledging the differences in the medical and midwifery philosophies, and, therefore, care, the literature describes what collaboration *should be*.

For example, Lindeke and Sieckert (2005) say collaboration *should be* the concerted effort of individuals and groups to attain a shared goal with mutual respect, trust, professional responsibility, and accountability. Lindeke and Sieckert's position on what collaboration *should be* is consistent with what most authors believe. In fact, D'Amour, Videla, Rodriquez, and Beaulieu's (2005) review of the literature notes a consensus among various authors regarding the concepts of collaboration: sharing, partnership, interdependency, power, and process. D'Amour et al. add that collaboration should include "a spirit of harmony" (p.116).

Johantgen, Fountain, Zangaro, Newhouse, Hutt, and White (2012) recently noted that "very little is understood about the full content and context of care provided during labor" (p. e78). Other authors suggest that future research include studies that enhance "understanding of how maternity care teams practice together most effectively" (Kennedy & Lyndon, 2008, p. 434). Skinner and Foureur (2010) call for future research to develop and enhance understanding of collaboration. Kennedy, Grant, Walton, Battista, and Sandall (2010) suggest that future research examine the processes of midwifery maternity care, while D'Amour, Videla, Rodriquez, & Beaulieu (2005) suggest that "collaboration needs to be understood not only as a professional endeavor, but also as a human process" (p. 128). The current study has met these calls for research by exploring the processes of what collaboration *is* as perceived by one party in a collaborative relationship, the CNM who works with physicians in U.S. hospitals.

SIGNIFICANCE

CNMs in the U.S. have been collaborating with physicians for decades with continued sociopolitical expectations of positive economic impact. The general problem

of collaborating has importance for CNMs and physicians who work together to provide maternity services. Economic advantages may be realized when the process of *behaving collaboratively* can be described and taught to healthcare professionals, thus affecting not only healthcare economics, but also education and organizations.

The basic social processes (BSPs) of collaboration have yet to be discussed in the literature even though substantial literature exists on what collaboration should be. No studies to date have addressed how to *behave collaboratively*, or if there is a process of collaborating. The present study explored the substantive area of interest: *behaving collaboratively* as perceived by the CNM.

The study examines CNMs' perceptions of how they make collaboration work with physicians in U.S. hospitals and discovers the *substantive theory of getting along*. Study findings may be meaningful for practitioners, educators, and organizations that are responsible for patients whose care depends on the processes of collaboration. The findings of the present study should advance knowledge for CNMs and physicians who work collaboratively in U.S. hospitals and has implications for collaboration within other medical practice area specialties and other professional fields.

OVERVIEW OF METHODOLOGY

Classical grounded theory (CGT) was selected for this study because it is the method most suitable for taking a preliminary or exploratory look into a phenomenon about which little is known (Glaser & Strauss, 1967). Classical grounded theory does not force preconceived ideas or extant theory onto data for the purpose of verification (Glaser, 1992). Instead, CGT defers to the experience of the participant who is familiar with the phenomenon of interest (Glaser, 2006). The conceptualization of participant

descriptions leads the researcher to identify *categories* and the *phases* or *outcomes* of a *basic social process (BSP)* as they relate to the phenomenon of interest. Classical grounded theory methodology is a rigorous research method that allows for systematic collection and analysis of data using the constant comparative method (CCM) as described by Glaser (1978, 1992, 1996, 1998, 2006, & 2012). Classical grounded theory is an iterative process that requires interaction between data collection and analysis. The data is first compared to itself and then to the new data. Constant comparison allows the emergence of a *BSP/core category*, and, ultimately, the generation of *substantive theory*. Classical grounded theory (CGT) will not withstand the scrutiny of the rigorous data analysis strategies if it is influenced by researcher preconceptions (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012). The researcher who conducts a CGT investigation is intently focused on the data and the processes of the methodology. Thus, CGT has built-in processes which diminish bias.

The goal of CGT is to generate *substantive theory* explaining a problematic pattern of behavior that is relevant and easily recognizable by those who experience it (Glaser, 1978). The iterative processes of *theoretical coding*, *theoretical sampling*, and *theoretical saturation* guided this classical grounded theory researcher to recognize repeating patterns, *codes*, and *categories*. The CGT researcher engages in many operations along multiple lines and in many directions, going back and forth among data, new data, concepts, and the inductive emerging theory (Glaser, 1978) to discover “what the data is saying” (B. Glaser, personal communication, May 18, 2012). Data analysis for the CNM Perception Study utilized these techniques described by Glaser (1967, 1978, 1992, 1996, 1998, 2006, & 2012). Combining the *constant comparative method* (CCM)

with the concurrent operations of *theoretical coding*, *theoretical sampling*, and *theoretical saturation* led to the discovery of the *behaving collaboratively BSP* and the generation of the *substantive theory of getting along*.

DELIMITATIONS

The purpose of study was to understand the CNM's perception of her collaborative role in U.S. hospitals. Delimitations of the study relate to sampling, methodology, and the phenomenon of interest.

Delimitations of Sampling

The use of purposive sampling was an intentional delimiting factor for the present study. Purposive sampling drew only from CNMs in the U.S. who worked with physicians in hospitals. Sampling this circumscribed group resulted in a project that was manageable and feasible. The sample was delimited further by recruiting English-speaking only participants from the membership of the American College of Nurse Midwives (ACNM). The final sample delimitation was that CNMs who did not have the skills necessary to participate in an online synchronous interview were excluded.

Delimitations of Methodology

Other qualitative research methodologies were deemed less appropriate and, thus, not selected for the current study. Classical grounded theory fit the research question and had the potential to contribute something new to the current fund of knowledge in this substantive area. The data collection strategy was delimited by the exclusive utilization of synchronous online interviews. Other data collection strategies such as surveys, or face to

face interviews were dismissed since online synchronous interviews were inexpensive and allowed for a greater geographic range.

Delimitations of the Substantive Area of Interest

The study focused on the perceptions of CNMs who work collaboratively with physicians in U.S. hospitals. The decision to delimit the study to a specific group who experienced a specific phenomenon arose from the researcher's interest in the substantive area and her background as a CNM.

CONCLUSION AND ORGANIZATION OF THE CHAPTERS

This dissertation is organized into five chapters, a reference list, and appendices. Chapter One has introduced the study. Chapter Two presents a review of the related literature dealing with CNMs and physicians as well as other healthcare professionals in collaborative practices. Chapter Three describes the study's research design and methodology of the study, including data collection procedures, sampling, and data analysis. Chapter Four provides a discussion of the study findings, including the *behaving collaboratively BSP*, the subcategories of *holding*, *adjusting*, and *releasing*, and the substantive theory of *getting along*. Chapter Five presents the discussion section of the dissertation with a synthesis of the research findings and the extant literature as well as conclusions and recommendations for future research.

Chapter 2 Review of the Literature

The second chapter of this dissertation is a pre-data collection analysis/review of the current literature. Chapter Two begins with the definition of the term Certified Nurse-Midwife and the introduction of literature supporting the significance of the current study as it relates to maternity healthcare, maternity healthcare economics, and healthcare provider education. A brief description the current position of the CNM within the U.S. healthcare systems will be followed by a history of collaboration among CNMs and physicians. Chapter Two will conclude with the general characteristics of collaboration as described by the literature.

The current study uses “Certified Nurse Midwife” or “CNM” to refer to midwives who:

... are educated in two disciplines: midwifery and nursing. They earn graduate degrees, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM. CNMs must demonstrate that they meet the *Core Competencies for Basic Midwifery Practice* of the American College of Nurse-Midwives and must practice in accordance with *ACNM Standards for the Practice of Midwifery*. ACNM competencies and standards are consistent with or exceed the global competencies and standards for the practice of midwifery as defined by the International confederation of Midwives. To maintain the designation of CNM, midwives must be recertified every 5 years by the American Midwifery Certification Board and must meet

specific continuing education requirements (Retrieved from:

<http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000002128/Midwifery%20Evidence-based%20Practice%20Issue%20Brief%20FINALMAY%202012.pdf>).

The term “midwife” is used to refer to all other kinds of midwives who have a variety of educational requirements and certifications.

The most common reason for hospitalization in the U.S. is for birth and care of the newborn (Levit, Wier, Stranges, Ryan, & Elixhauser, 2009). Even though the majority of women and their newborns are healthy, the cost of maternity care is staggering (Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012). Around the world, interprofessional collaboration has been identified as crucial to the development of high-quality, cost-effective healthcare systems (D’Amour, Videla, Rodriguez, & Beaulieu, 2005; Thuente & Friedrich, 2008). The purpose of this study was to generate a classical grounded theory related to the processes of collaboration, from the perspective of CNMs, as they work with physicians in hospitals in the U.S. to address the research question: “How does the CNM perceive her collaborative role with physicians in U.S. hospitals?”

The following sections review the literature related to collaborative practice, giving special attention to collaboration between midwives and physicians. The sections begin with a brief description of the current literature related to CNMs’ impact on the cost of maternity services in the United States, followed by a discussion of the meaning of the term “collaboration,” followed by an overview of the history of collaboration among CNMs and physicians in the U.S., and concluding with the characteristics of collaboration.

U.S. CNMs AND MATERNITY CARE

Healthcare systems in the U.S. have a long history of merging issues of cost containment and adjustments for economic changes with advances in scientific knowledge and increasingly complex healthcare needs (MacDonald, Herbert, & Thibeault, 2006; Downe, Finlayson, & Fleming, 2010). The cost of maternity care in the U.S. has been estimated to represent one-fifth of all healthcare expenditures (Goodman, 2007). The Agency for Healthcare Research and Quality estimated that the cost of caring for pregnant women and newborns to exceed 86 billion dollars in the 2006 fiscal year (Andrews, 2006). Gabay and Wolf projected in 1995 that as much as 20 billion dollars could be saved by developing midwifery practices. In light of the current high-cost of healthcare and the emphasis on cost containment, it is not surprising that the number of births attended by American CNMs has been rising steadily (Schuilling, Sipe, & Fullerton, 2010; Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012). “CNMs are seen as a potential solution [to U.S. healthcare needs]” (Johantgen et al., 2012, p. e74). According to studies which controlled for confounding variables, found that when compared to their physician colleagues, CNMs use fewer interventions, their patients have a lower rate of cesarean deliveries, and their patients’ babies have better morbidity and mortality rates (Harris, Janssen, Saxelle, Carty, MacRae, & Pettersen, 2012; Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012; Raisler, 2000).

Although the majority of CNMs in the U.S. practice in hospitals in collaboration with physicians (Retrieved from: <http://www.mymidwife.org/history.cfm>), these collaborations are not without their challenges. An important challenge arises from differing philosophical viewpoints: the physician views birth as a potentially hazardous

event while the CNM views birth as a normal physiologic event (Miller, King, Lurie, & Choltz, 1997; Miller, 1997; Kennedy, Levi, & Kane-Low, 2006). These two philosophies are not mutually exclusive, but are, at times, in opposition; they are compatible in so much as birth is mostly normal and sometimes complicated. The opposition of the two philosophies lies in the blurry line between normal and complicated.

COLLABORATION DEFINED

Collaboration has been defined or described by a variety of sources, including in Federal law (Crecelius, 2011), by the American Nurses Association (2001), by the ACNM (2002), and various researchers. Federal law addresses collaboration in relation to advanced practice nursing (APN): Subsection (aa) (6) states that the term:

‘Collaboration’ means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner’s professional expertise. The medical direction and appropriate supervision is provided in jointly-developed guidelines or other mechanisms as defined by the law of the State in which the services are performed (Retrieved http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#ft239).

The American Nurses Association (ANA) 2001 Code of Ethics describes and defines collaboration in Section 2.3 as more than cooperation:

. . . it is the concerted effort of individuals and groups to attain a shared goal. By its very nature, collaboration requires mutual trust, recognition, and respect among the health care team, shared decision-making about

patient care, and open dialogue among all parties who have an interest in and a concern for health outcomes (Retrieved from: <http://www.nursingworld.org>).

The 2002 joint position of the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) defines some of the attributes of collaboration:

. . . the quality of those practices is enhanced by a working relationship characterized by mutual respect and trust as well as professional responsibility and accountability. When obstetrician-gynecologists and certified nurse midwives/certified midwives collaborate, they should concur on a clear mechanism for consultation, collaboration and referral based on the individual needs of each patient (Retrieved from: http://www.midwife.org/siteFiles/position/Joint_Statement_05.pdf).

Each of these statements views collaborative practice as CNMs and physicians working together with mutual respect, trust, professional responsibility, and accountability to meet the healthcare needs of women. On the other hand, they do not say what the clear mechanisms are for consultation, collaboration, and referral.

The literature shows we have limited understanding of the complex relationships involved when healthcare professionals collaborate (D'Amour, Videla, Rodriquez & Beaulieu, 2005). According to D'Amour et al., healthcare professionals "...are socialized to adopt a discipline-based vision of their patients and services, which lead to rigidly

circumscribed professional jurisdictions” (p. 117). Other authors have attributed this discipline-based socialization to philosophical differences (Miller, King, Lurie, & Choltz, 1997; Miller, 1997; Kennedy, Levi, and Kane-Low, 2006). Although most authors believe that philosophical baselines should be congruent, D’Amour et al. note that “conflicting beliefs and values foster collaboration while placing restraints on it” (p. 122). In other words, philosophical differences generate the reason for collaborating, but power differentials restrain how much collaboration is allowable. In the case of CNMs and physicians, the baseline philosophy is seen in the shared outcome goal of a healthy mother and neonate, yet the ways in which each profession attains the goal may differ. It is the difference in attaining the common goal that explains the challenges behaving collaboratively. The underutilization of CNMs in the U.S. and restraints on collaboration are a result of medical hegemony which marginalizes all other models of maternity care, including the attempt to normalize birth through midwifery (Goodman, 2007).

Henneman, Lee, and Cohen (1995) conducted a concept analysis of the term “collaborate,” using the techniques prescribed by Walker and Avant (1988). Their goal was to identify the definitions, defining characteristics, antecedents, and consequences related to the concept as it applies to nurses and physicians working together in the hospital setting. The authors referred to Webster’s Third New International Dictionary (1986) that included a definition of “collaborate” as “willingly working with an enemy of one’s own country” (p. 104). Henneman et al commented on the association with the enemy:

The definition of collaboration as an association with the enemy may, at first glance, appear to be an unrelated or illegitimate case as it relates to

health care. However, collaboration in healthcare frequently is used in reference to the relationship between two, sometimes adversarial groups, namely physicians and nurses. Hence, the definition suggestive of cooperation with the enemy may, in fact, most closely capture the meaning of collaboration for many nurses and physicians in the practice setting (p. 104).

A comprehensive definition of collaboration can be found in a review of the literature by D'Amour, Videla, Rodriguez, and Beaulieu (2005). The authors' goal was to develop an understanding of the complex phenomenon of collaboration based on the current state of knowledge. D'Amour et al. accomplished this goal by describing the concepts of collaboration and by identifying conceptual frameworks for collaboration. D'Amour et al. offer another definition of collaboration which speaks to healthcare environments and professional interactions among collaborators:

Our working lives are always set in collective environments with constant interactions with others. These interactions take different forms, one of which is collaboration. The term collaboration conveys the idea of sharing and implies collective action oriented toward a common goal, in a spirit of harmony and trust, particularly in the context of health professionals.

Because the growing complexity of health problems, it is important to have a better understanding of interprofessional collaboration (p. 116).

The literature review by D'Amour et al., (2005) concluded that, even though there is considerable diversity in the ways various authors conceptualize the term, the concept of collaboration can be defined through five concepts: sharing, partnership,

interdependency, power, and process. Sharing refers to shared responsibilities, decision-making, healthcare philosophy/values, planning, and interventions. Partnership is described as a collegial, authentic, constructive relationship in pursuit of common goals. Interdependency refers to a mutual dependence in which the members of a team contribute to maximize outcomes. The concept of power is conceived as being based on knowledge and experience rather than on functions, ranks, and titles. Finally, the process evolves whereby collaboration requires negotiation of professional boundaries occur so that each provider can make his or her maximal contribution to patient care.

D'Amour et al. (2005) also explored extant conceptual frameworks for collaboration. The authors found that most collaborative practice frameworks address the tasks of and settings for collaboration, but do not address the processes of collaboration. As a result, the authors note, these studies do not assist in understanding what “transpires in the working lives of a group of collaborating professionals or the nature of their interactional dynamics” (p. 126).

The definitions of collaboration were discussed to begin the process of understanding complex collaborative relationships. The current study was informed by the history of CNM's collaborating with physicians in U.S. hospitals.

HISTORY OF U.S. CNM AND PHYSICIAN COLLABORATION

Managed health care systems in the United States began employing Advanced Practice Nurses (APNs), including CNMs, in collaborative practices during the 1960s (Hooker, 1994). However, CNMs currently attend less than 12% of births in the U.S. as compared to 50% -75% of births attended by midwives in other developed countries (Goodman, 2007). It is interesting to note that more than 30 years elapsed before

economic concerns forced a peaked interest in the topic of collaboration and researchers began to investigate and publish on the topic of collaborative practice.

An entire 1997 issue of the journal *Women's Health Issues* (WHI) was devoted to collaborative practice for maternity services. The journal included six articles: one was a scientific inquiry and five were descriptive; only two articles provided references. The journal articles included the proceedings of the first national conference, "Models of Collaborative Practice: Preparing for Maternity Care in the 21st Century (Corry, Williams, & Stapleton, 1997)." The WHI articles called for making collaborative practice a topic of future research and suggested that research should be directed to three specific areas and based on the premise that all studies would be based on sound scientific design. The first recommended area of future research was to be on cost savings, outcomes, and patient satisfaction related to collaborative practice. The second recommended area for future research was to identify key variables separating successful models of collaboration from models that fail. The final recommended area was that future research should define pedagogy that promotes attitudes and skills necessary for collaborative practice.

Among the articles in the WHI issue was a study by Miller, King, Lurie, and Choltz (1997) that focused on collaboration between CNMs and physicians. Miller et al. developed a survey instrument to quantitatively measure clinical collaboration, financial structures, and issues of conflict in collaborative practice. Data was collected by an internet survey, using a convenience sample consisting of 17 CNMs and five obstetricians who represented a variety of collaborative practices. One finding was that

collaborative practice does not have a universal meaning. The authors suggest there may be degrees of collaborative, practice from minimally collaborative to wholly supervisory.

The WHI issue included a second study by Miller (1997) who used grounded theory methodology to understand collaborative practice and to explore the attitudes and experiences of providers who work in collaboration. Miller conducted telephone interviews with ten CNMs and five physicians and combined the data from the earlier internet survey described above (Miller, King, Lurie, & Choltz, 1997) with the telephone data. Although the combined data and subsequent analysis did not result in a better understanding of collaborative practice, it identified five antecedents for collaborative practice among CNMs and physicians.

The five antecedents identified by Miller (1997) as necessary for successful collaboration include amenable external conditions, amenable individual attributes, amenable organizational dynamics, equality of attitude/trust/power, and similar practice philosophies. Miller's first antecedent included three essential components for successful collaboration, *amenable external conditions*, included institutional policies, legislation, and the political socioeconomic conditions surrounding individual collaborative practices. The second antecedent, *amenable individual attributes* included competence and confidence, which she believed each member of the collaborative practice team expected of the other. The third antecedent, *amenable organizational dynamics*, included the ground rules (such as open communication and conflict resolution), decision-making by consensus, commitment to role clarity in collaboration, and a nonhierarchical structure (including similar financial compensation). The fourth antecedent, *equity of trust and power*, focused on the attitudes of collaborative practice team members, with an emphasis

on taming medical hegemony. The final antecedent referred to the importance of *congruent practice philosophies*, which included dedication and commitment to the care of individual women, their families, and their communities. Miller and her colleagues suggested that compatibility between individuals and organizations, equity of power and trust, and congruent philosophies are necessary for effective collaboration.

CHARACTERISTICS OF COLLABORATION IN MATERNITY CARE

Making collaboration work amid the professional rivalries and philosophical differences in maternity care is not simple (Henneman, Lee, & Cohen, 1995; Lurie, & Choltz, 1997; Miller, 1991; Kennedy & Lyndon, 2008; King & Miller, 1997; Reiger, & Lane, 2009). In fact, Kennedy, Levi, and Kane-Low's (2006) metasynthesis of qualitative research related to CNM practice revealed that collaboration among CNMs and physicians is difficult, contentious, and complex. Difficult collaborative relationships are largely due to power inequities (domination of the medical model) and the philosophical differences, including how CNMs and physicians view birth (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, & Fleming, 2010; Goodman, 2007; Hastie & Fahey, 2011; Keating & Fleming, 2009; Kennedy & Lyndon, 2008, Lane, 2012; Reiger & Lane, 2009). Goodman (2007) commented that the underutilization of CNMs in the U.S. and restraints on collaboration are the result of medical hegemony that marginalizes all other models of maternity care, including the attempt to normalize birth emphasized in midwifery.

Professional rivalries and philosophical differences may not be exclusively problematic to CNMs and physicians. In fact, professional rivalries and philosophical differences may be common between other types of healthcare providers. Kennedy and

Lyndon's (2008) ethnographic study explored the relationship between U.S. registered nurses trained for labor and delivery (RNs) and CNMs in a tertiary maternity care center. The study found philosophical differences between CNMs and RNs that were comparable to those noted by others between physicians and CNMs (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, & Fleming, 2010; Goodman, 2007; Hastie & Fahey, 2011; Keating & Fleming, 2009; Lane, 2012; Reiger & Lane, 2009). The Kennedy and Lyndon study identified "tensions and teamwork" as characteristics of the relationships between CNMs and RNs. Tension resulted primarily from the CNMs' perception that the RNs did not support their philosophy of normal birth. The CNMs also perceived that RNs had differing philosophies about safety, communication, respect, and pain management. On the other hand, both the RNs and CNMs were committed to working together for the women in their care and agreed that "teamwork was an ongoing process that could be improved" (p. 431).

Several studies from the U.S. highlighted how power inequities are a cause of contention in the collaborative relationship between midwives and physicians (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, & Fleming, 2010; Goodman, 2007; Kennedy & Lyndon, 2008). Australian studies also supported the notion that power differentials were at the root of the contentious relationships between midwives and physicians (Reiger & Lane, 2009; Hastie & Fahey, 2011). Reiger and Lane (2009) found power struggles in Australian public hospitals were a source of conflict. "Problems of incivility are further exacerbated in public hospital environments in which increasingly fragmented labour force struggles with intensified work demands (p. 316)". The Hastie

and Fahey (2011) study further noted that “turf wars” between medicine and midwifery are still common” (p. 77).

Keating and Fleming (2009) used a feminist approach to explore how Irish midwives perceived facilitating normal birth in the hospital setting. Keating and Fleming’s study findings indicated that the Irish midwives’ main concerns were issues related to organizational hierarchy, power and prestige, and domination by physicians. Patriarchy was the major theme identified. The Irish midwives perceived the hierarchical order to begin with the doctors at the top, midwives below (with a subhierarchy of senior and junior midwives), and the patients on the bottom. Keating and Fleming clearly suggest that hierarchical thinking allocates more power and prestige to the doctors.

The literature is replete with discussions and investigations into the CNMs’ potential impact, inside and outside of the hospital, on the cost of maternity services in the U.S., and the potential cost effectiveness of hospitals hiring more CNMs. Raisler’s (2000) study compared health outcomes in patients attended by CNMs and physicians and pointed out CNMs used fewer interventions; their patients had lower cesarean section rates, and lower infant morbidity and mortality rates. Raisler’s study controlled for confounding variables when comparing CNMs and physicians, despite positive health outcomes, in 2009, CNMs were responsible for only 11.4 % of births in the U.S. (Retrieved 11/3/2012 from: <http://www.midwife.org/CNM/CM-attended-Birth-Statistics>), although in other developed countries midwives are responsible for 50% -70% of births (Goodman, 2007). Given the positive healthcare outcomes associated with CNM care, increasing the use of CNMs could bring about significant cost saving in U.S. healthcare.

CONCLUSION

The literature reveals that, whether in the hospital or in another setting, most CNMs work using collaborative arrangements with physicians. Even though a number of definitions and characteristics of collaboration are contained in the extant literature, for the most part, there is agreement that the term “collaboration” connotes working together with mutual respect, trust, professional responsibility, and accountability. The literature does not address how CNMs who work with physicians in U.S. hospitals negotiate Henneman, Lee, and Cohen’s (1995) “working with the enemy.” Designating a practice as “collaborative” does not ensure a mutually respectful, and trusting relationship between CNMs and physicians, nor that CNMs and physicians recognize each others’ skills and abilities. The current study addresses this gap in the literature by describing the basic social process of “making collaboration happen” on a day-to-day basis. The goal of this classical grounded theory study was to develop *substantive theory* that explains and predicts a systematic view of phenomena by specifying the interrelationships between meaningful concepts, using definitions and hypotheses (Glaser, 1978).

Chapter Three describes the methodology utilized in this study which was guided by Glaser’s classical grounded theory approach (1965, 1978, 1992, 1996, 1998, 2006, & 2012). The study explored the research question, “How does the CNM perceive her collaborative role with physicians in U.S. hospitals?”

Chapter 3 Methodology

Around the world interprofessional collaboration has been identified as crucial to the development of high-quality, cost-effective healthcare systems (D'Amour, Videla, Rodriguez, & Beaulieu, 2005). The lack of data regarding the certified nurse midwife's (CNM's) perception of her intrapartum collaborative role limits the development of collaborative relationships that could significantly transform and improve maternity care maternity healthcare services. Literature regarding the process of collaborating is nonexistent. The purpose of this study was to discover the basic social process (BSP)/core category and generate a substantive classical grounded theory related to collaboration from the perspective of CNMs who work with physicians in U.S. hospitals. The research question was "How does the CNM perceive her collaborative role with physicians in U.S. hospitals?" The overall objective of The CNM Perception Study was to enhance understanding of collaborative practice between CNMs and physicians based on rich descriptions provided by CNMs.

Chapter three presents classical grounded theory (CGT) methodology which was utilized in the study to explore the research question, "How does the CNM perceive her collaborative role with physicians in U.S. hospitals?" This chapter presents the study sampling procedures, recruitment strategies, and participant selection criteria; followed by detailed descriptions of data collection procedures, data management; concluding with the data analysis process, which included coding, the constant comparative method (CCM), theoretical sampling, theoretical saturation, and memoing. The chapter includes a discussion of Glaser's (1978) four criteria for rigor and how those criteria were met in the

study. The chapter concludes with a discussion of ethical issues related to the study and the procedures for protecting research participants.

PROBLEM STATEMENT

The CNM Perception Study used CGT to explore how CNMs working with physicians in U.S. hospitals make collaboration work (Glaser & Strauss, 1967; Glaser, 1978; 1992, 1996, 1998, 2006, 2009, & 2012). The study examined collaboration as a process occurring among a specific group of people in a specific context with the ultimate goal of identifying a basic social process (BSP) from which substantive grounded theory could be developed.

Classical grounded theory frequently is associated with symbolic interactionism, even though Glaser and Strauss (1967) do not identify a philosophical foundation for their method. Glaser (2006) later rejected the notion of classical grounded theory being steeped in symbolic interactionism as “patently wrong” (p. 5). Glaser (2006) believes that classical grounded theory (CGT) is not guided by one theoretical perspective and does not need an epistemology. Nathaniel (2012) also argues against the association of CGT with symbolic interactionism. She suggests that other authors have “proposed piecemeal explanations of the method’s ontological, epistemological, and methodological underpinnings, thus promoting erosion and remodeling of the grounded theory method and creating a variety of notions about the method’s philosophical foundation” (p. 187). The current study sides with Glaser in rejecting the idea that CGT needs an epistemology.

Classical grounded theory (CGT) is a method suitable for taking an unbiased, preliminary, or exploratory look into a phenomenon about which little is known (Glaser & Strauss, 1967). CGT is a rigorous research methodology that allows for systematic

collection and analysis of data, the discovery of a BSP/core category, and ultimately, the generation of substantive theory. Classical grounded theory methodology is focused on the data, which reveals the participants' main concerns. The resolution of participants' main concerns forms the basis for the BSP/core category and the substantive grounded theory. How the participants resolve their main concern is determined through the constant comparative method (CCM). Built into the CCM is data verification which restrains researcher biases and prejudices (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012).

Glaser says the researcher must strive to understand “what is going on” (B. Glaser, personal communication, May18, 2012) to discover the participants' main concern. This CGT study sought to understand the main concern of CNMs who work in hospitals with physicians by asking, “How does the CNM perceive her collaborative role in the hospital?”

STUDY SAMPLING

Glaser (1978) says the classical grounded theorist must have “a general sociological perspective about a substantive area within a population, not a preconceived problem or hypothesis” (p. 36). The goal of the CNM Perception Study was to understand collaboration from the perspective of the CNMs who work with physicians in U.S. hospitals. Moreover the goal of the current study was to understand if collaboration was a main concern.

The study used purposive and theoretical sampling. Purposive sampling selects subjects because of who they are and what they know (Glaser, 1978). Therefore, purposive sampling is based on the characteristics of the participants (Siegel, 2002). All

participants were CNMs working with physicians in U.S. hospitals. Since CGT requires concurrent collection, coding, and analysis of data, theoretical sampling also was used. Theoretical sampling is “seeking pertinent data to develop [the] emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories . . . [and] develop the [ir] properties” (Charmaz, 2006, p. 96). In other words, theoretical sampling asks different questions of new participants within the purposive sample. Theoretical sampling is important to theoretical saturation, both of which will be discussed in more detail in the data analysis section.

PARTICIPANT SELECTION CRITERIA

Inclusionary criteria for participation were

- a CNM working in a collaborative hospital practice in the U.S.
- able to speak, read, and write in English
- had access to a computer and had the necessary computer skills to participate in the online interview

Exclusionary criteria for participation were:

- CNMs working in a collaborative practice outside of the hospital setting
- unable to speak, read, and write in English
- did not have access to a computer and/or did not have the necessary skills for the online interview.

There were no exclusionary criteria related to gender, ethnicity, or race. Participant recruitment ceased when data analysis revealed saturation at 14 interviews and was confirmed at 16 interviews. Saturation occurred when no new categories emerged from

new data and ample representation of each category had been collected (Glaser & Strauss, 1967).

RECRUITMENT

The study proposed using online participant recruitment and online synchronous participant consent and data collection. A protocol was submitted to the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB) for approval. IRB approval #11-071 was received on April 4th, 2011, for the CNM Perception Study (Appendix A). Following the UTMB IRB approval, four CNM participants were recruited as participants of a pilot study that demonstrated the feasibility of the data collection methods and allowed for minor adjustments to be made in the recruitment and consent strategies and the interview questions. These adjustments did not require resubmission of the protocol to the UTMB IRB; the entire study was conducted under IR approval #11-071.

Participants in the current study were recruited from the membership roster of the American College of Nurse Midwives (ACNM) which has a national membership greater than 7000. Appendix B documents the ACNM's permission to access the online email roster. Prior to the email solicitation of participants, 100 flyers (Appendix C) were handed out at the ACNM's annual convention in May 2011 which did not result in the recruitment of any participants. Subsequently, the ACNM randomly selected 2500 ACNM members, all U.S. residents with current email addresses, to receive email invitations to participate (Appendix D). Eighteen CNMs responded to the invitation to participate, two did not meet selection criteria, and 16 were enrolled in the study.

CNMs interested in the study could respond directly to the researcher's email address, or for further study details, were directed to: <http://cnmperceptionsstudy.blogspot.com/>. The blog spot included instructions for anonymous participation (Appendix E). All participants responded to the researchers UTMB email address and were subsequently contacted to schedule an interview appointment (Appendix F). Participants could either participate anonymously or use an existing e-mail address with the understanding that this choice would reveal their identity to the researcher. Those who chose to use an existing email address were informed that they might sacrifice anonymity since the researcher would know their names, but were assured of confidentiality. Seven of the 16 CNMs chose to participate anonymously; the remaining participants used an existing email address.

Study Participant Demographics

A total of sixteen female CNMs participated in the study; 87.5 % identified themselves as white; their ages ranged from 27-59 (mean = 50). The study participants had an average of 14 years experience (range: 1-30 years) and represented 13 states across the continental U.S. The participants were similar in race/ethnicity and age, to the ACNM national membership statistics. The current study participants were 87.5 % Caucasian women, whereas ACNM membership is reported at 91.9% Caucasian. The mean age of study participants was 50, as compared with the mean age of 53 for ACNM members. Differences in the educational level of study participants as compared with the ACNM membership statistics existed: a higher percentage of study participants CNMs held both bachelors and masters degrees. Table 1 compares study participant demographic data to the most recent demographic data available from the ACNM

(Retrieved 11/4/2012 from:

http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/0000000001720/CoreDataSurvey_2010_one-pager.pdf).

Table 1

Study Demographics (2012) to ACNM Demographics (2010)

Demographic Measures	Participants	ACNM Membership
Female	100%	98.7%
Caucasian	87.5%	91.9%
Age Range	27-59 years	23-85 years
Mean Age	50	53
Years of Experience	1-30 ($X = 14$)	1-60 (mean not given)
Bachelors in Nursing	93.75%	51.6%
Masters in Nursing	100%	51%
Doctoral Degree	6.2%	8.4%
Hospital-Attended Birth	100%	the majority

DATA COLLECTION PROCEDURE

The researcher, who is English-speaking only, conducted all interviews. The study utilized online synchronous interviews for the purpose of data collection.

Synchronous online data collection is a relatively novel way of collecting qualitative data. There are advantages and potential disadvantages to using this technique.

Advantages include the ability to recruit participants from a wider geographic area (as opposed to face-to-face interviews) and the ability to save the intact interview transcript.

On the other hand, Bjerke (2010) suggests that a potential disadvantage of online interviews may be establishing rapport due to the inability of both the participant and the researcher to view nonverbal cues. This researcher believes that nonverbal cues can be prejudicial. Moreover, Gruber, Szmigin, Repell, and Voss (2008) report that other qualitative researchers have overcome issues of rapport by using acronyms (such as LOL

meaning laugh out loud), abbreviations (u for you, ur for your), commonly used emoticons (such as smiley faces), and making small talk at the beginning of the interview. The data collection experience during the first four interviews led the researcher and her mentor to believe that rapport had been easily established, in part because the participants and the researcher were members of the same group and in part because the researcher used a conversational-type tone, small talk, emoticons, acronyms, and abbreviations.

All CNMs who were interested in participating in the study contacted the researcher at either her personal email account, set up specifically for the study, or at her work email address. The researcher responded, asynchronously, by email, to each CNM who expressed interest in the study (Appendix F). Appointments for synchronous online interviews were set at times mutually convenient for the participants and the researcher.

Data collection began at the prearranged date and time, when the participant and the researcher logged into the g-mail chat forum. The researcher and CNM acknowledged each other, usually by typing a “hi” or “hello.” The researcher introduced herself and asked, “Is now still a convenient time to chat?” Most participants responded with a “yes.” The researcher then asked the participant to read a description of the study, followed by the consent script which delineated each aspect of the subject consent process (Appendix G). The CNM participant was informed that the transcript, from log-in to sign-out, would serve as a record of her study involvement. The researcher asked the CNM if she had any questions about the study or her willingness to participate. Once the researcher had answered all of the CNM’s questions, the researcher asked the CNM if she agreed to the terms and conditions of the study and to indicate her understanding by typing “agree”

to participate or “decline” to opt out of participation. None of the CNMs refused to participate in the study, nor did any opt out before the interview was completed.

The participant’s typed agreement allowed the researcher to begin collecting demographic data, which constituted the first part of the interview. Demographic data included information such as age, gender, race/ethnicity, education, and work experience (Appendix H). Following the collection of demographic data, the semi-structured interview portion of data collection began. The interview questions had been developed specifically for The CNM Perception Study (Appendix I). Examples of questions asked by the researcher were: “Describe the ideal collaborative hospital practice,” and “Tell me a story about when collaborating worked well.” At the conclusion of the interview, the researcher asked the participant if there was anything else the CNM would like the investigator to know about the topic of collaboration. The data collection sessions ended with the researcher thanking the CNM for participating and extending an invitation for the participant to email additional thoughts or comments to the researcher (no further comments were received by the researcher). The researcher also confirmed the participant’s willingness to be contacted by email should the researcher have further questions; each participant agreed. The researcher did not contact the participants following their interviews, as classical grounded theory does not subscribe to member checking; instead, CGT requires the researcher to respect the intact data that was shared by study participants. Finally, participants were asked if they were interested in receiving the results of the study. All participants indicated they were interested and each CNM will receive a personal email containing a synopsis of study results at the conclusion of

the study. The one-time interviews lasted an average of 88 minutes, ranging from 55-129 minutes.

DATA COLLECTION SETTING

The researcher collected online data in her private home office or private work office, using a password-protected computer, and a secure network connection. Every participant chose her own interview location and time. Participants were encouraged to choose a setting where they would not be interrupted and could maintain privacy and confidentiality while at their computers. Data was not collected related to the location of CNM participant, although some participants incidentally mentioned their locations during the interviews.

DATA MANAGEMENT

Data from the online synchronous sessions were saved on the researcher's computer and thumb drive, both of which were password-protected and stored securely in a locked cabinet in the researcher's office. The original transcripts were saved intact on the researcher's computer. A second copy of each transcript was made from the original intact interview, all identifiers and demographics were removed from that copy, and each line of data was given a participant code and a subscript line number. The subscript line number allowed the researcher and her mentor to return to the context of the data when/if necessary. Occasionally, participants divulged information that could be linked to them, such as hospital, or city in which they worked, or names of their colleagues; all such information was removed. The second copy of each transcript, de-identified as described, also was saved on the researcher's computer and thumb drive. Hard copies were made from the de-identified interview-only portion of the transcripts to be utilized for data

analysis. The interview portion of the transcript was arranged on the page to provide room for memoing, notes on constant comparisons, and mentor comments. All forms of data related to the study will be destroyed at the study's conclusion.

DATA ANALYSIS

Data analysis for the CNM Perception Study utilized the *constant comparative method* (CCM), as described by Glaser (1978, 1992, 1996, 1998, 2006, 2009, & 2012). The CCM is the foundation for data analysis when using CGT. The intention of CCM is to analyze the data by comparing data to itself and to other data before collecting additional data. The classical grounded theorist uses CCM for coding, in theoretical sampling, theoretical saturation, and memoing.

CODING

The CCM used for data analysis in the present study was first described by Glaser and Strauss (1967). CCM is an iterative process of examining, categorizing, and coding the collected data (Glaser, 1992); CCM continuously compares incidents to incidents and incidents to categories to discover meaningful properties of categories. During the initial process of coding the data, CCM assists the researcher to look for patterns in the data (Glaser, 1998).

Two types of coding constitute the core of grounded theory: substantive and theoretical (Glaser, 1978). *Substantive* coding begins when the grounded theorist has no categories and may not even know what his study is “really” about (Glaser, 1992, p. 40). Glaser (1978) says this is the time in CGT when the researcher must be able to tolerate the confusion of not yet knowing what the data has to reveal. Glaser (1998) compares CCM to “*explication de text*,” a literary technique whereby text is read, line by line,

comparing incidents to incidents while asking, “What category or property of a category does this incident indicate?” (p. 24). Incidents are identified and examined for patterns to create as many categories as possible. While creating as many categories as possible the researcher may feel confusion (Glaser, 1978). Recognizing similarities amongst incidents, which are given a conceptual name that represents what is going on in the data, a category is a conceptualization — Glaser refers to this process as “conceptualizing up” (B. Glaser, personal communication, May 18, 2012). In addition to identifying categories, substantive coding allows the grounded theorist to begin to also identify links among categories. As substantive coding continues, the second type of coding, theoretical coding begins.

The second type of coding that constitutes the core of grounded theory is *theoretical* coding. Theoretical coding begins by integrating substantive codes into a theory. Glaser (1978) says theoretical coding “...conceptualizes how substantive codes relate to each other as hypotheses...” (p. 72). Relationships among categories through CCM lead to the discovery of the core category that emerges when one category becomes consistently related to many other categories. Glaser (1998) refers to the process of theoretical coding as the emergence of “the latent structural pattern of the substantive theory” (p. 26).

Theoretical Sampling

Theoretical sampling is not to be confused with the separate and distinct process of theoretical coding. Theoretical *sampling* “constantly focuses and delimits the collection and analysis of data, so that the researcher is not collecting the same data over and over,” using the same questions (Glaser, 1998, p.157). As a result, the interview

questions are modified to determine the properties of the categories or to confirm the emerging theory.

Theoretical sampling is not an easily isolated, stepwise process of CGT; it happens while the classic grounded theorist “engages in many other operations, along multiple lines, and in many directions, going back and forth between data, new data, concepts, and the inductive emerging theory” (Glaser, 1978, p. 37). The classical grounded theorist must be able to tolerate the confusion that comes with identifying multiple categories and going back and forth between data and concepts during the processes of theoretical sampling (Glaser, 1978, 1996, & 1998). The operations of theoretical coding and theoretical sampling are concurrent, but theoretical sampling allowed this researcher and her mentor to return to data collection and confirm the properties of each category through the collection of additional data. Glaser (1978) explains that theoretical sampling confirms the links among categories that the researcher has discovered. The links among categories constitute the movement that occurs in a basic social process (BSP). The basic social process explains the research topic from the standpoint of those involved.

The technique of theoretical sampling provides the synchronization and direction for concurrent data collection coding, analysis, and ultimately, category saturation. Theoretical sampling is the “where next” in collecting data, the “for what” in the codes (categories and properties), and the “why” from the data analysis (Glaser, 1998, p. 157). Although the process is labeled theoretical sampling, it is actually theoretical data questioning. While sampling the data for the emerging categories, the researcher asks, “Where does the data lead, for what purpose, and why?” Subsequently, the answers

emerge in the new data. Thus, theoretical data questioning confirms what is already learned and directs the researcher on the path of discovering what is missing.

Theoretical Saturation

Like theoretical coding and theoretical sampling, *theoretical saturation* is a concurrent operation. Saturation is recognizable when no new codes, categories, or properties are identified and the same codes, categories, and properties recur (Glaser, 1998, p. 53). Theoretical sampling and theoretical saturation are, according to Glaser, “not based on numbers or a representative sample” (p. 159). Theoretical saturation is a consequence of theoretical sampling. The outcome of theoretical saturation is a “well integrated grounded substantive theory with parsimony and scope” (p. 159).

The concurrent operations of theoretical *coding*, *sampling*, and *saturation* were evident in the evolution of the interview questions asked of participants in the CNM Perception Study. For example, early in data analysis, questions emerged about the terms, consulting and collaborating: did the participants use the terms *consulting* and *collaborating* to refer to different concepts? Did the participants use the terms *consulting* and *collaborating* to refer to the same concept? The interview questions evolved, and the participants were asked whether they perceived a difference in *collaborating* and *consulting*. As a result, from this new data, separate properties of the terms *collaborating* and *consulting* emerged that directed the evolution of new interview questions. Theoretical sampling continued until the properties of *collaborating* and *consulting* became saturated; by the time the 14th participant is asked, “Is consulting the same as collaborating?” her response confirmed the separateness of the two concepts.

Memos

Glaser (1992) says there are requisite skills the grounded theorist needs for data analysis. Among these requisite skills is an ability to absorb the data, the ability to distance or step back from the data, and an ability to abstractly conceptualize the data. *Memoing* is a crucial element in the process of data analysis and theory development. This skill allows the researcher to absorb as well as distance herself from the conceptualized data. Classical grounded theory does not subscribe to separate reflective and methodologic journals. Rather, CGT reflections are maintained as on-going documentation of the researcher's and mentor's thoughts, questions, prejudices, and ideas about the data — memos “freeze the moment” (Glaser, 1998 p. 177). Glaser also says memoing is how concepts and ideas “pour out, ” In memoing the researcher is able to document ideas and allow for the ideas and concepts to mature.

Memoing encourages creativity and autonomy (Glaser, 1998). Memos for this study were written on the deidentified transcripts, on the computer, on post-it notes, and on whatever was available when ideas arose. For example, on the first participant's transcript the researcher wrote, “does consulting mean giving up?” Early memos like this spurred ideas about possible properties of consulting. The researcher's note on the second participant's transcript asked, “does collaboration require friendly relationships?” The memo caused the researcher and her mentor to begin to consider how the properties of collaboration might be similar to or different from those of consulting. The properties of consulting became clear, leading the researcher to note on the tenth participant's transcript, “Consulting is formalizing the interaction between CNM and physician.” This memo became particularly important to the study's findings.

Glaser (1992) emphasizes the importance of memos and explains that memos are the “theorizing write-up of ideas as they emerge while coding for categories, their properties, and their theoretical codes” (p. 108). The sorting and conceptualization of memos leads to theory formulation; thus, memos are critical to CGT data analysis (Glaser, 1998).

Sorting Data

Study data consisted of the demographic data and interviews collected during the synchronous online sessions as well as the researcher’s memos. As the amount of data grew, it became clear that an organized method for sorting data, codes, and memos was necessary. Initially, each interview transcript was analyzed and substantively coded; notes and memos were written on each transcript. A second hard copy of the transcripts was made so that incidents from different interviews could be cut out of the transcript and placed with conceptually similar incidents; the collections were placed in small clear plastic bags and labeled with proposed codes, categories, and properties. This technique was useful throughout substantive coding, theoretical coding, theoretical saturation, identification of the basic social process and the core category. The technique also kept the data organized and functioned as a bookmark allowing the researcher and her mentor to return to the exact place in the data analysis process.

Constant comparison and reflection on the data within and among the small clear plastic bags led the researcher and her mentor to conclude that some of the ideas contained within the smaller bags were conceptually similar to each other. As a result, the small clear plastic bags with similar concepts were placed in medium-size clear plastic bags. The data was “conceptualized up” (B. Glaser, personal communication, May 18,

2012) into larger, more inclusive concepts, and new conceptualized labels were placed on the outside of the medium-size clear plastic bags. Theoretical sampling continued as additional interviews were analyzed, coded, cut up, and placed in the clear plastic bags. The categories and/or properties of categories became saturated when new interviews did not reveal additional categories or properties. Finally, it was the links among categories that revealed a *basic social process/core category* and a *substantive grounded theory*.

CORE CATEGORIES

A core category is important in CGT because it represents the main theme or, as Glaser (1978) says, “A core category is the main concern or problem for the people in the setting” (p. 94). For example, the CNMs in the current study identified *behaving collaboratively* as problematic. Glaser also notes that a core category will meet the following criteria:

1. will be central
2. will recur frequently as a stable pattern
3. will relate easily and meaningfully to other categories and/or properties
4. will account for variation in the problematic behavior
5. will have ‘carry-over,’ and
6. will have clear, grabbing implications for formal theory (pp. 94-96).

Chapter Four will explain how Glaser’s criteria were met as they specifically related to the findings of the current study.

BASIC SOCIAL PROCESS

A basic social process (BSP) is a type of core category with additional criteria (Glaser, 1978, p. 96). “The primary distinction between a core category and a BSP is that BSPs are ‘processural’ or they ‘process out’ (pp. 96-97).” A BSP is the process by which

the problematic pattern of behavior is resolved. Consequently, BSPs have two or more clear phases with conditions and consequences which cause movement over time. Glaser says, “BSPs are theoretical reflections and summarizations of the patterned, systematic uniformity, flows of a social life which people go through, and which can be conceptually captured and further understood through the construction of BSP theories” (p. 100).

Two final terms that will assist the reader in understanding a BSP are *phases* and *outcomes*. A category or the properties within a category may become *phases* or *outcomes* and are dependent upon conditions. As conditions change, *phases* and *outcomes* are the consequences that indicate movement over time, making a CGT *modifiable*. A property becomes a *phase* when it indicates *movement* within the BSP. *Phases* are not stagnant — they are flexible and result in *movement* through the categories. This *movement* can be forward or backward to the next category or the next *phase*. It is important to note that movement in and out of the categories is not always linear or irreversible. Moreover, if there is no *movement* to the next *category* or property, the property becomes an *outcome*. *Outcomes* are a consequence of *movement* within a BSP.

SUBSTANTIVE THEORY

Substantive theory as described by Glaser (1978) explains and predicts how a specific group of people who share a problematic experience in a particular setting deals with that problem. Glaser says substantive theory “fits the real world, works in predictions and explanations, is relevant to the people concerned, and is readily modifiable” (p. 142). Substantive theory can provide the basis for the development of a formal theory, although formal theory exists on a conceptually different level of

generalizability. Where substantive theory relates directly back to the substantive area, formal theory is generated by comparing different substantive theories, but goes beyond one particular substantive area (Glaser, p. 145).

SCIENTIFIC RIGOR

Scientific rigor for the current study was accomplished through safeguards against researcher bias. In this study, Glaser's four criteria were applied for judging and legitimizing a classical grounded theory: *fit*, *workability*, *relevance*, and *modifiability* (1978, 1992, & 1998).

Researcher bias is always a concern for the qualitative researcher. The current study addressed issues of bias and prejudice through strict utilization of CGT methodology. Classical grounded theory requires intense focus on the data and the process of constant verification. The classical grounded theorist defers to the experiences of participants while attempting to identify their main concern (Glaser, 2006). Moreover, the CCM has built-in data verification which restrains researcher bias and prejudice (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012).

Glaser also suggests that substantive theory will not hold together if it is invented from researcher preconceptions (1998). Although the researcher is a CNM who works in collaboration with physicians in a U.S hospital, her mentor is not a CNM. Thus, the mentor provided peer review throughout all phases of the study, directly countering possible researcher bias.

Further facilitation of assuring scientific rigor is Glaser's (1978) use of *fit*. Glaser says *fit* is another word for the quantitative equivalent of validity and is achieved through constant comparison. *Fit* means that the conceptualization (theory) describes the data

patterns. In other words, the emergent categories must be grounded in (*fit in*) the data. Categories that *fit* neither can be preconceived nor forced; they emerge from the data and will, therefore, automatically *fit* the theory. The study data revealed a *behaving collaboratively BSP* with categories of *holding*, *adjusting*, and *releasing*. Movement within the *behaving collaboratively* categories explains how the CNM's resolved the problem of working collaboratively with physicians in U.S. hospitals. The phases and/or outcomes of the *behaving collaboratively BSP* fit the theory of *getting along*.

Workability refers to the recognizable conceptual hypothesis, accounting for how the main concern (core category) in the substantive area is continually resolved (Glaser, 1998). In general, *workability* is what makes the main concern recognizable to anyone who has experienced it. The CNMs who were interviewed for the present study identified *behaving collaboratively* as problematic. The data collected in the current study revealed that the CNM's main concern was *getting along*. The theory of *getting along* describes a *behaving collaboratively BSP* which has *workability* because it interprets what happened and predicts what will happen when CNMs work collaboratively with physicians in hospitals (Glaser, 1978).

Glaser's third criterion for rigor in CGT is *relevance*. Glaser says (1978), "Grounded theory arrives at *relevance* because it allows core problems and processes to emerge" (p. 5). The results of the current study arrived at *relevance* by drawing from the CNMs' perceptions of what was important to them about collaborating with physicians in U. S. hospitals. Glaser (1978) also says *relevance* is what makes the research important: it provides "grab" (p. 4). Glaser uses "grab" to mean the study arouses interest or excitement, particularly to those who have experienced the phenomenon (B. Glaser,

personal communication, May 18, 2012). The researcher presented preliminary study findings to selected CNM colleagues, each of whom recognized elements of their own experiences, thus, revealing *relevance* from within.

Finally, Glaser (1978) says CGT should be *modifiable*. He notes that good CGT “will be *modifiable* to new conditions, new subjects, and perspectives on the same problem, provided that the problem is *relevant* in the new area” (1992, p. 24). Martin (2012) describes *modifiability* in relation to Glaser and Strauss’s (1965) *Awareness of Dying*. Martin says Glaser and Strauss did not intend their theory to be the final word on awareness; instead, they “laid out what could be viewed as a research program for a broader theory of awareness for anyone looking to take up the challenge” (p. 298). *Modifiability* is what happens when the ideas within one substantive theory form a platform for other scientific inquiry or even the development of formal theory (Glaser, 1978 & 2012). *Modifiability* is what turns a CGT into science — theory that emerges directly from data using the techniques of CGT is never right or wrong, but it is *modifiable* by new conditions (Glaser, 1998). The substantive theory that emerged from the CNM Perception Study meets the criteria of *modifiability* in that the *behaving collaboratively BSP* and the substantive theory of *getting along* have the potential to be common among all advanced practiced nurses who collaborate with physicians in hospitals, thus, forming a platform for other scientific inquiry across disciplines leading to the development of formal theory on collaboration in healthcare.

ETHICS, PROTECTION FROM RISKS, AND BENEFITS OF PARTICIPATION

All study procedures in this research activity were in compliance with standards set forth by the University of Texas Medical Branch (UTMB) Institutional Review Board

(IRB) and the American College Nurse Midwives (ACNM) IRB for safeguarding the rights and welfare of the study participants. The CNM participants are not considered members of any vulnerable population.

The CNM Perception Study collected data via synchronous online interviews, which potentially could have resulted in a breach of confidentiality. The literature supports the low risk of breaching confidentiality for participants in online studies. Brownlow and O'Dell (2002) suggest that internet communications are similar to letters or phone calls where privacy is expected and intended although interception is a possibility. While most people do not regard internet communication interception as a serious threat, there is mention of the possibility in the informed consent (Appendix G).

The study design reduced the risk of breaching confidentiality by giving participants the option of anonymous participation (Appendix E). Confidentiality also was protected through the assignment of participant codes, the removal of demographic information (prior to data analysis), and the removal of all personal identifiers from the interview narratives. The participant data quoted in the findings are identifiable by participant code, only.

Participation in the study was voluntary, and the participants determined the amount of time and type of information they shared during the interview. During the consent process and prior to beginning the interview, participants were informed of their freedom to withdraw from participation at any time. No participants exercised their right to withdraw or to end the interview prior to its conclusion.

CONCLUSION

Chapter Three has provided a detailed description of this study's research methodology. Classical grounded theory methodology was selected for this study that explored the processes involved when CNMs try to resolve *behaving collaboratively* with physicians in U.S. hospitals. The chapter has described the methods which allowed for the emergence of categories for the *behaving collaboratively BSP* and the generation of the substantive theory of *getting along*.

Chapter Four will provide the conceptualization of the study's findings while identifying specific strategies used in analyzing the data. Chapter Four also will provide precise findings and will illustrate how substantive theory was generated from the data analysis.

Chapter 4 Findings

The purpose of this study was to generate a classical grounded theory (CGT) related to the processes of collaboration from the perspective of CNMs as they work with physicians in U.S. hospitals to address the research question: “How does the CNM perceive her collaborative role with physicians in U.S. hospitals?” The researcher sought to determine whether a better understanding of the phenomenon of *behaving collaboratively* would lead to the discovery of a substantive theory explaining how CNMs work in collaboration with physicians in U.S. hospitals. The *specific aim* of the study was to provide an understanding of collaboration as perceived by the CNM. By utilizing a classical ground theory approach to study a phenomenon of interest, this study resulted in a core category and substantive theory of *getting along* for CNMs who work collaboratively with physicians in U.S. hospitals. The core category and substantive grounded theory emerged through constant comparison of incidents which led to the three main subcategories of the basic social process (BSP) of *behaving collaboratively*: *holding, adjusting, and releasing*.

This chapter presents four key findings obtained from 16 in-depth interviews with CNMs who work collaboratively with physicians in U.S. hospitals:

1. Three Subcategories
2. The Basic Social Process
3. The Core Category
4. The Theory

The chapter is organized around the four key findings from the CNM Perception Study which utilized CGT methodology (Glaser, 1965, 1978, 1992, 1996, 1998, 2006, & 2012). Glaser suggested that CGT should be parsimonious in the use of participant quotations for the purpose of focusing the reader on the substantive theory. Therefore, Chapter Four judiciously includes a limited number of participant quotations in order to not distract the reader from the substantive theory. The chapter begins by presenting some important presumptions as they were described by the CNM participants. The presumptions are followed by a discussion of the criteria for a core category and the additional criteria for a BSP. Subsequently, the chapter identifies the three subcategories discovered in the current study. Following the discussion of the three subcategories and their properties, a discussion of the links among the categories will demonstrate the BSP, the emergence of the core category, and the substantive grounded theory. This chapter will guide the reader forward to an understanding of how the substantive theory of *getting along* interacts with the BSP and how the CNMs used the BSP to continually resolve the problem of behaving collaboratively.

CNM PARTICIPANT PRESUMPTIONS

Analysis of the data revealed that the CNMs' responses reflected certain presumptions about working collaboratively with physicians in U.S. hospitals. These presumptions related to the CNMs, the physicians, and to the patient. The CNMs consistently perceived that the midwife and the physician constituted the collaborative team. Many of the participants said the collaborative team was made up of the CNMs and physicians because these providers were the "decision-makers." Therefore, while acknowledging there are many important professionals who comprise a collaborative

maternity care team, the reader should understand that any references to the *collaborative team* members in this report refers to the CNM and the physician.

The CNM study participants identified three kinds of patients: *my patient*, *our patient*, or *their patient*. There is a continuum of patient condition in maternity care that can be visualized as ranging from uncomplicated to complicated. Traditionally, CNMs are qualified to care for uncomplicated patients, while physicians care for patients with complicated pregnancies. The patients in the middle of the continuum can be managed either by the CNM, by the physician, or both. When a CNM referred to a patient as “my patient,” she was indicating that she was independently taking responsibility for the care of that patient. When the CNM referred to the patient as “our patient,” she was referring to the patient being managed by both the CNM and the physician. The last kind of patient described by the CNM participants was “their patient,” meaning the patient was cared for by one or more physician(s). Thus “my patients” were CNM patients, “our patients” were CNM/physician patients, and “their patients” were physician patients.

FINDING 1: THREE SUBCATEGORIES

The CNM Perception Study examined collaboration as a process occurring among a specific group of people (CNMs) in a specific context (U.S. hospitals) with the ultimate goal of generating a substantive grounded theory through the identification of the *behaving collaboratively BSP*. Keeping in mind the CNMs’ presumptions related to the collaborative team and the patient, the following discussion illustrates each subcategory with its properties and its *phases* or *outcomes*. The discussion will lay the foundation for clarifying the *behaving collaboratively BSP*, the *core category*, and the *substantive grounded theory*.

Holding (“my patient”)

The first category to emerge from the data related to the BSP was *holding*.

Holding occurred when the CNM was independently managing the care of the laboring patient. The CNM viewed herself as the patient’s *independent guardian* and viewed the patient as “my patient.” The Merriam Webster Online Dictionary (2012) defines guardian as “one that guards; custodian: one who has the care of the person or property of another” (Retrieved 10/31/2012 from: <http://www.merriam-webster.com/dictionary/guardian>). CNMs perceived it was their duty, as a patient’s guardian, to protect the best medical interests of that patient.

Each of the CNM participants described *independent CNM guardianship* in some way. One CNM expressed her capability of functioning without supervision when she said, “So we manage our patients independently (participant 10, line 32).” Another CNM’s statement identified the magnitude of the *independent CNM guardianship*: “We attend over 60% of all deliveries at the hospital” (participant 9, line 3). Yet another CNM added, “It is very important to me to have my independence, especially as I feel that what I do as a CNM is unique and not a mini MD (participant 12, line 19).” *Independent CNM guardianship* according to another CNM meant something a little different: “The midwives are the default for a woman coming into the hospital in labor” (participant 5, line 6). This CNM’s use of the word “default” reflects the Merriam Webster Online Dictionary (2012) which describes “default” as “an automatic selection” (Retrieved 10/31/12 from: <http://www.merriam-webster.com/dictionary/default>). Thus, the CNM indicated that all patients were initially and automatically placed within *independent*

CNM guardianship. The patient's laboring status determined how long she would remain within *independent CNM guardianship*.

Holding, characterized by *independent CNM guardianship*, had one major condition that specifically related to the physician: *Be ready if I need you*. This condition was a consequence of the CNM's perception of the physician as a resource, to be called upon if needed. A resource is: "a source of supply or support: an available means (Retrieved 10/31/12 from: <http://www.merriam-webster.com/dictionary/default>). One CNM identified the physician as her resource or support when she wrote, "There is always an OB in the hospital, and he/she is available for consult" (participant 5 line 7).

The CNMs perceived this condition of *be ready if I need you* as a necessary component for *getting along* with her physician colleague while the patient was within *independent CNM guardianship*. The CNMs also perceived that the major condition was subdivided into three expectations: *Leave me alone*; *Don't come [if I don't call]*; and *Come when I call*. All CNMs gave examples of the condition *be ready if I need you*, and most examples also illustrated the CNM's expectations. One CNM commented, "If I am comfortable with the situation I do not talk or text them [physicians], a kind of no news is good news scenario" (participant 13, lines 7 & 20). Here, the CNM participant quotation exemplifies: *Be ready if I need you*, but *leave me alone*.

The CNMs provided examples that demonstrated *Be ready if I need you* condition with *Don't come [if I don't call]* expectation. One CNM recounted a time when she was caring for a patient in early labor. The CNM entered her patient's room and found a "doctor explaining to my patient that, really, all babies should be born by cesarean section" (participant 4, lines 8-10). The CNM further stated, "I was pretty appalled"

(participant 4, line 14). Another CNM described being concerned about her patient's baby although not sufficiently concerned to require the physician's input. The CNM reported that she subsequently discovered "... the attending MD sent the residents into my patient's room" (participant 1, lines 13 & 24). In each of these instances, the CNM did not ask for, nor did she need, the physician's unique capabilities. As a result, the CNMs indicated they were not *getting along* with their physician colleagues in the *holding* category of the BSP when the physician demonstrated mistrust by breaching the *Don't come [if I don't call]* expectation within *independent CNM guardianship*.

The final *Be ready if I need you* condition with the *come when I call* expectation were repeatedly expressed by CNMs: the CNMs indicated they expected the physician to respond to their calls for assistance. This expectation was a consequence of the CNMs' assumption that the physicians understood that the CNM would not request the physician's assistance unless the patient's laboring status warranted it. The CNMs knew they shared the responsibility of assuring the physician would be responsive to the CNMs' notification about the change in patient's laboring status. One CNM wrote, "I think the CNM has the responsibility to give succinct reports to the MDs, whenever necessary, and to ask specifically for what is needed from the physicians" (participant 13, line 68). The CNM went on to explain that if she needed the physician's skills, she would say so. Clearly, participant 13 believed her physician colleague met the *Be ready if I need you* condition and her *Come when I call* expectation. Another example was offered by a CNM who said of her collaborating physician, "He comes when I call and doesn't ask if I've tried everything" (participant 6, line 12). When the major condition and corresponding expectation were met, the CNMs perceived that they were *getting along*

with their physician colleagues while the patient was in *independent CNM guardianship* in the *holding* category.

It was possible that *independent CNM guardianship* during the *holding* category could stop the BSP and become an *outcome* if conditions and expectations were satisfied. In order for *independent CNM guardianship* to become the *outcome*, the patient's laboring status had to remain unchanged throughout the course of her hospital stay. If, however, there was a change in the patient's laboring status, *movement* in the BSP was initiated and *independent CNM guardianship* became a *phase*. *Movement* in the BSP would lead to the next category: *adjusting*.

Adjusting (“my patient” vs. “our patient”)

Adjusting is the second category of the BSP and was the result of a change in the patient's condition. *Adjusting* happened when the CNM involved the physician in the care of the patient. Physician involvement ranged from informal and peripheral to formal and central. The *adjusting* category had three possible *outcomes* or *phases*: *checking in*, *consulting*, and/or *merging*.

CHECKING IN

The first phase of *adjusting* was *checking in*. *Checking in* occurred when the CNMs merely wanted to talk with the physician about the patient's laboring status. *Checking in* reflected the CNM's assessment that the patient's condition did not require physician attention; she merely wanted to engage in an informal discussion with the physician. One CNM said, “Sometimes I just give them a text or an FYI, don't want them to do anything or say anything, just informing them” (participant 13, line 8). Another participant described *checking in*: “Upon finding a patient with potential problems, I will

discuss with the MD team and let them know I am comfortable taking care of the patient” (participant 1, line 9). Another CNM described a situation in which she had assessed a patient who had been sent to the hospital for evaluation and determined her to be appropriate for CNM care. The CNM also sent a text message to the physician including a report of the patient’s condition and the CNM’s plan of care. The physician replied “OK,” and the CNM proceeded to care for the patient (participant 13, line 4). CNMs also *checked in* with physicians to review a plan of care: “If I have a situation, perhaps a high-risk patient, I will give the docs a rundown and make sure they agree with my plan of care” (participant 13, line 24). The CNMs also *checked in* if the patient’s condition was high-risk: “I’m clear that I need to review my decision making...I usually review my evaluation to be sure I haven’t missed something. With some docs I review the plan as I’m ordering things” (participant 5, lines 39-40). The CNMs also used *checking in* for patients whose laboring status might require physician attention. For example, some CNMs who want to use a drug to augment labor must first *check in* with their physician colleagues, “That is really just a notification . . . ‘are you OK with us continuing?’ or ‘are you OK with this strip [fetal heart rate tracing]?’ They very often will say it’s fine to continue” (participant 8, lines 30 & 32).

Checking in during the *adjusting* category could stop *movement* in the BSP. For *movement* to stop the BSP the patient’s condition had to remain unchanged throughout the course of her hospital stay. Thus, *checking in* became the *outcome* in the *adjusting* category. If, however, there were a change in the patient’s laboring status, *movement* within the category resulted in *checking in* becoming a *phase*. In the *adjusting* category, the *phase* or *outcome* following *checking in* was *consulting*.

CONSULTING

The second possible *phase* or *outcome* in the *adjusting* category was *consulting*. The CNMs were consistent in their definition of the term: *consulting*: “Consulting is to get their ideas, opinions for proceeding in a situation” (participant 15, line 1). *Consulting* was more formal than *checking in*. One CNM wrote: “If an official consult is being requested, our physician wants to come in, see the patient, and write a note” (participant 9, lines 54 & 67). The CNM participants acknowledged their opinions might differ from those of physicians. One participant stated, “We don’t always agree, but, like I said earlier, if we are asking their advice, we feel we need to follow it if we can’t negotiate a happy medium” (participant 8, lines 34 & 35). Perhaps the most succinct definition of *consulting* came from the CNM who wrote; “A consult is a formal request for an expert opinion” (participant 10, line 82).

The CNMs also described three steps in the process of *consulting*. In the first step, the CNM identified the possible need for physician input with the CNM subsequently providing the physician information regarding the patient’s laboring status. In the second step of the process of *consulting*, the CNM informed the physician what actions had been taken and the effect, if any, on the patient’s laboring status. In the third step of *consulting*, the CNM discussed her plan for the continued care of the patient with the physician, which could result in several possible *consequences*. The most common *consequence* of formally requesting an expert opinion was the physician agreeing to the CNM’s plan and the patient remaining in the CNM’s care. As a result, there would be no further movement in the category of *adjusting*; instead, movement in the BSP returned to the first category, *holding*. Another possible *consequence* of *consulting* was the *merging* of

the unique capabilities of the CNM with those of the physician to co-manage the patient's care. *Merging* became the last *outcome* or *phase* in the *adjusting* category. The final possible *consequence* of *consulting* was that the CNM and physician jointly determined the patient's care was not suitable for the CNM, and an agreement was reached whereby the patient's care would be *released* by the CNM to the physician. *Releasing* will be described in greater depth following the discussion on *merging* since *releasing* is the final category of the *behaving collaboratively* BSP.

MERGING

Merging occurred when the patient's status required the CNM to combine her skills with the unique skills of the physician, resulting in the patient becoming "our patient." One CNM participant wrote: "We each offer our unique approach, and as we share patients, they get something from each of us" (participant 5, line 46). Another participant wrote: "We 'co-manage' a patient's care and the patient receives consistent care from both parties" (participant 7, line 13). Another participant concluded: "I think we work together to try to provide the best care for our patients" (participant 16, line 23). *Merging* occurred when the patient's laboring condition became sufficiently complicated that it required a blending of the unique skills of the CNM with those of the physician. One participant wrote, "The CNMs collaborate with the MDs for patients/labors that are outside the realm of normal" (participant 13, line 3). Another CNM wrote, "I may ask the physician to use a vacuum to assist with the delivery and that is part of us all working together" (participant 9, line 18). This CNM explained that she continued to care for the patient following the use of the vacuum. The CNMs perceived that *merging* was

important to working together and *getting along* to reach their shared goal of providing the best possible patient care.

In summary, the *adjusting* category began with informal *checking in* where the CNM continued to provide the patient's care. During *checking in* the physicians involvement was informal and peripheral. If there were no change in the patient's laboring status, the *outcome* was *checking in*. Nevertheless, *checking in* could become a *phase* if there were a change in the patient's laboring status. A change in the patient's laboring status would cause *movement* within the BSP to the next *phase* or *outcome*: *consulting*. During *consulting* the CNM would follow the advice of her physician colleague and if the patient's condition remained unchanged throughout the remainder of her hospital stay, *consulting* became the *outcome* of the *adjusting* category. *Consulting* became a *phase* when a change in the patient's condition caused *movement* within the BSP to the next *phase* or *outcome*: *merging*. *Merging* combined the unique skills of the CNM with those of the physician and became the *outcome* if the patient's condition remained unchanged throughout the remainder of her hospital stay. *Merging* became a *phase* when a change in the patient's condition caused *movement* within the BSP to the next category: *releasing*. It should be noted that it was possible for changes in a patient's condition to move the *behaving collaboratively BSP* back to a previous category or pass over entire *phases* and *categories* to reach the goal of providing patients with the best possible medical care.

Releasing ("their patient")

The final category of the *behaving collaboratively BSP* was *releasing* which occurred when the patient's laboring status required her care to be assumed by the

physician. The patient then became “their [the physician’s] patient.” One CNM wrote, “It is my role to know when to turn them [the patients] over completely and when to bring them back to my management” (participant 15, line 73). Another CNM described a time when she was caring for a patient who came to the hospital in labor. The CNM evaluated the patient and determined the patient was in premature labor; the baby was not due for more than 12 weeks. The CNM’s assessment led her to pass over the categories of *holding* and *adjusting* and move directly to *releasing*. She wrote: “Then I got the Doc in there and turned care over to him...He was the responsible provider” (participant 14, lines 24-25). This quotation illustrates movement where entire *categories* and *phases* were skipped because of the patient’s condition.

Releasing could occur in any *category* or in any *phase*, illustrating that *movement* within the *behaving collaboratively BSP* was driven solely by the patient’s condition. Another example in which the participant described *releasing* occurred in the postpartum unit:

We had a patient who developed a complication after having her baby. I called my backup MD who came into the hospital, agreed with the diagnosis, and took the patient immediately to the operating room; the process was seamless in this instance (participant 1, lines 40-41).

There were no sub-properties or *phases* of *releasing*. Nonetheless, when *releasing* occurred, it did so in a variety of ways, sometimes abruptly, sometimes through a long process of moving through the categories and phases of *holding* and *adjusting*. In the case of the patient whose baby came 12 weeks early, Participant 14 illustrated a time when *releasing* occurred abruptly.

On the other hand, a patient who begins her labor in the *holding* category, within the *independent CNM guardianship*, might progress to a situation that causes the CNM to

become concerned and to seek the physician's expert opinion on how to proceed. *Movement* within the BSP then would occur from *holding* to *adjusting*, but not yet to *releasing* because the CNM continued to care for the patient using the recommendations of the physician. However, if the patient's labor progressed to pushing and the CNM realized that the mother was not making sufficient progress toward delivery, the CNM might skip the *merging* phase of *adjusting*, and go directly to *releasing* by asking the physician to perform a cesarean section. In each of these cases, *releasing* was the *outcome* resulting from *movement* through the *categories* and *phases* of the BSP.

FINDING 2: THE BASIC SOCIAL PROCESS

Holding, adjusting, and releasing demonstrate three distinct phases with conditions and consequences that cause change or movement over time (Glaser, 1978, pp. 94-100). *Holding, adjusting, and releasing* constitute the BSP *behaving collaboratively*.

Glaser's (1978) first criterion for a BSP that it should have two or more phases was met in the emergence of the three categories of the *behaving collaboratively* BSP: *holding, adjusting, and releasing*. *Holding* became a *phase* if *adjusting* became necessary and *adjusting* became a *phase* if *releasing* became necessary. Thus, the clearly defined phases of *holding, adjusting, and releasing* met Glaser's first criterion for a BSP.

Glaser's (1978) second criterion for a BSP is that it changes or moves over time. The *behaving collaboratively* BSP with its phases of *holding, adjusting, and releasing* met this criterion as illustrated by changes in the patient's laboring status. If the patient's laboring status changed, there was *movement* in the BSP from one category to the next.

Glaser's (1978) final criterion for a BSP is that the BSP has conditions and consequences. The *holding, adjusting, and releasing* categories met Glaser's final

criterion for a BSP. Each category or phase within the *behaving collaboratively BSP* was dependent on the patient's condition. Changes in the patient's condition led to the consequences of physician involvement in the patient's care.

FINDING 3: THE CORE CATEGORY

A core category demonstrates centrality by meaningfully relating to all of the subcategories accounting for the variation in the pattern of behavior (Glaser, 1978, p. 95). Study findings indicated that the main concern of the CNMs in the current study was *getting along* with their physician colleagues. The current study's core category, *getting along*, meets Glaser's (1978) criteria because it was central, occurred frequently as a stable pattern, related easily and meaningfully to the other categories and properties, had carry-over, accounted for the variation in the problematic behavior, and had clear and grabbing implications for formal theory. All three sub-categories: *holding*, *adjusting*, and *releasing* related easily to the core category: *getting along*. In general, the CNMs perceived they were *getting along* when the CNM and the physician were in agreement regarding the patient's care. For example, during the *holding* category, the CNM and physician *got along* by working independently but were aware of one another. The physician agreed to be absent from the patient's care but available if needed. In the *adjusting* category, the CNM began to involve the physician in the care of the patient. The physician involvement ranged from informal and peripheral, *checking in*, to formal and central, *consulting* and/or *merging*. When the patient's laboring status warranted, the CNM and physician formed a team to care for the patient. *Getting along* was a condition necessary in the *adjusting* category as the

CNM and physician worked together to reach their mutual goal of providing the best care for the patient. Finally, *releasing* related easily to *getting along* when the CNM and the physician agreed the patient's condition was no longer suitable for CNM care.

Glaser (1978) says that a category becomes core if it recurs frequently in the data and it relates easily and meaningfully to other categories and their properties. In the *holding* category the CNMs resolved the problem of behaving collaboratively with a major condition and three expectations. During *independent CNM guardianship* the CNMs perceived they were *getting along* if the physician met the condition of *Be ready if I need you*. Additionally, the CNMs perceived they were *getting along* if the physician met three expectations. The CNM's first expectation was for the physician to *Leave her alone* to care for the patient in *independent CNM guardianship*. When the CNMs were *left alone* to do what they are trained to do and the patient's condition remained stable, the CNMs believed they were *getting along*. The CNM's second expectation for the physician during the *independent CNM guardianship*, was that the physician would not participate in the care of the patient unless invited to do so: *Don't come [if I don't call]*. In the case where the CNM believed the physician breached the *Don't come [if I don't call]* expectation, the CNMs considered the physicians responsible for *not getting along*. Finally, the CNM's third expectation for the physician was that if the CNM believed the physician's unique capabilities were needed by the patient, the physicians would respond (*Come when I call*). The CNMs believed they were *getting along* when the physician met the expectation of *coming when called*. Consequently, the *holding* category relates meaningfully to the core category of *getting along*.

In the *adjusting* category the CNMs resolved the problem of behaving collaboratively by means of *checking in*, *consulting*, and *merging*. *Checking in*, *consulting*, and *merging* involved the exchange or sharing of information between the CNM and the physician. During *checking in*, the CNM merely shared information with the physician; *checking in* facilitated *getting along*, especially if the physician might be needed for a later change in the patient's status. During *consulting*, the CNM shared information with the physician and expected the physician to either offer an endorsement or additional information. The CNMs perceived they were *getting along* with the physicians when they exchanged information more formally by *consulting*. The final exchange of information in the *adjusting* category occurred with *merging*. During *merging*, the CNM perceived there was an equal exchange of information and capabilities from CNM to physician and physician to CNM, all on behalf of assuring the patient's welfare. Exchanging information led the CNMs to perceive they were *getting along* during *merging*. Consequently, the sub-category of *adjusting* occurred frequently, related meaningfully, and lent further support to the core category, *getting along*.

The final sub-category, *releasing*, was described by all CNMs, and ultimately resolved the problem of behaving collaboratively. The CNM and physician behaved collaboratively when the patient's laboring status required that her care be released by the CNM to be assumed by the physician. *Releasing* was meaningfully related to the core category of *getting along*. One CNM illustrated the importance of *getting along* during *releasing*. The CNM called the available physician after having determined the patient needed a vacuum- assisted delivery. Consequently, the sub-category of *releasing* related meaningfully to the core category *getting along*.

Glaser (1978) says “a core category has ‘carry-through’ when it does not lead to dead ends in theory, but instead it leads to a substantive grounded theory that is relevant in its explanation and it resolves the problematic behavior in the substantive area” (pp. 95-96). The problematic substantive area in the CNM Perception Study was behaving collaboratively.

Glaser’s (1978) last criterion for a category to become core is that it must have “clear and grabbing implications for formal theory” (p. 95). In the context of this study Glaser means that the substantive theory of *getting along* and the *behaving collaboratively* BSP of *holding, adjusting, and releasing* for CNMs who work with physicians in U.S. hospitals may be a basic social process for anyone, in any setting, who behave collaboratively.

FINDING 4: THE SUBSTANTIVE THEORY

The integration of the data and memos in the current study discovered codes in the data, and the integration of these codes resulted in a substantive theory of *getting along*. Classical ground theory methodology was developed for generating substantive theory. Glaser (1978) says substantive theory concerns a specific group of people in a particular setting who share a problematic experience. Substantive theory explains and predicts how those people resolve a problematic phenomenon. Moreover, Glaser says substantive theory “fits the real world, works in predictions and explanations, is relevant to the people concerned, and is readily modifiable” (p.142).

The substantive theory of *getting along* fits the real life experiences of CNMs who work with physicians in U.S. hospitals. CNMs in the current study perceived behaving collaboratively as embodying their shared problematic experience.

Furthermore, the *behaving collaboratively* BSP, as categorized by *holding*, *adjusting*, and *releasing*, explains how the CNMs were able to resolve the problematic phenomenon of *behaving collaboratively*. The BSP also predicts the consequences of modifiable conditions. In other words, the BSP can be modified to work within a variety of situations. In the current study, the BSP was modifiable based on the patient's condition. Although the substantive theory of *getting along* described in this dissertation relate only to the CNMs who participated in the study, *getting along* potentially may pertain to a variety of collaborative contexts within healthcare.

CONCLUSION

This chapter has presented the findings revealed by the CNM Perception Study. Study findings were organized around the three sub-categories of *holding*, *adjusting*, and *releasing* that in turn constituted the BSP. The study also discovered and the core category and substantive theory of *getting along*. Data from individual CNM interviews revealed the research participants' perceptions of their experiences of working collaboratively with physicians in U.S. hospitals.

Initial findings revealed *holding*, *adjusting*, and *releasing* as the three main sub-categories within the data. As data collection progressed properties, conditions, and consequences of each category also were revealed as participants described their processes of *behaving collaboratively*. Data analysis led to an understanding of how the CNM resolves the problem of *behaving collaboratively* through a basic social process, that their main concern was *getting along*, and the discovery of the substantive theory of *getting along*. The substantive theory explains how CNMs resolved the problem of working collaboratively with physicians in U.S. hospitals.

Chapter Five, the discussion section of this dissertation, presents a synthesis of the research findings, conclusions, and recommendations.

Chapter 5 Discussion

The current study generated a classical grounded theory (CGT) related to the processes of collaboration from the perspective of certified nurse midwives (CNMs) who work with physicians in hospitals in the U.S. The purpose of the final chapter of this dissertation is to provide an overview of the study, which includes a review of the methodology, a review of the study findings in relation to the extant literature; discussion of unexpected findings, study strengths, study limitations, and implications for action; and recommendations for future research.

REVIEW OF METHODOLOGY

The current study had four important findings as a result of using CGT methodology. The first finding was the discovery of three subcategories that constituted the basic social process (BSP) *holding*, *adjusting*, and *releasing*. The second finding was the discovery of the *behaving collaboratively BSP*. The third and fourth findings were the *core category* and the *substantive theory of getting along*.

The findings of the current study addressed a gap in the literature. Although the literature supports the *idea* of collaboration, prior to the current study, the *processes* of collaborating had not been identified, which made CGT a particularly well-suited method for answering the research question, “How does the CNM perceive her collaborative role with physicians in U.S. hospitals?”

Classical grounded theory methodology is a rigorous research approach that guards against researcher preconception, prejudice, and/or bias because the methodology insists on being focused on and grounded in the data (Glaser, 2006). It is the data that

reveals the *categories* and the *phases* or *outcomes* which become the BSP (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012).

The ultimate goal of CGT is to generate *substantive theory*. *Substantive theory* emerges from the data to explain and predict a phenomenon of interest (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012). The goal of the current study was to generate *substantive theory* related to CNMs' perceptions of behaving collaboratively with physicians in U.S. hospitals. Through conceptual definitions of the *categories* and *phases/outcomes*, the BSP revealed propositional relationships or links which became the *substantive theory* of *getting along*. The *substantive theory* of *getting along* explained how and why CNMs resolved the problem of behaving collaboratively with physician in U.S hospitals. The *behaving collaboratively BSP* also predicted how the CNM would behave in order to *get along* with her physician colleagues, and, to a great extent, the CNM's expectations of how the physicians should behave.

To explain behaving collaboratively, or any phenomenon of interest, the classical grounded theorist goes back and forth between data and new data and concepts using the *constant comparative method* (CCM) to recognize repeating patterns while adding the concurrent operations of *theoretical coding*, *theoretical sampling*, and *theoretical saturation*. The operations of CGT are iterative and rigorous, and produce findings that are useful and meaningful (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012).

THE RESULTS IN RELATION TO THE EXTANT LITERATURE

The following discussion includes the study results with an integrated explanation of how the literature relates to the study findings. Glaser (1978) says a grounded theory explains and predicts how a specific group of people who share a problematic experience

and a main concern, in a particular setting, deal with that problem. The CNMs who participated in the study consistently identified *behaving collaboratively* with their physician colleagues as the problematic experience. Glaser describes dealing with a problematic behavior as how that specific group of people resolves the problem; in the case of the present study, “How do CNMs resolve behaving collaboratively with physicians in U.S. hospitals?” Data analysis revealed that the CNMs resolved *behaving collaboratively* through the BSP categories or phases of *holding*, *adjusting*, and *releasing*.

Glaser (1978) also suggests that people who share a problematic experience also have a shared main concern. The study findings indicate that CNMs were mainly concerned about *getting along* with their physician colleagues as they sought to resolve the problem of behaving collaboratively. The CNMs perceived that when they were *getting along* with their physician colleagues they moved through the phases *holding*, *adjusting*, and *releasing* with beneficial results to all — healthcare organizations, healthcare providers, and patients. The literature supports the study findings. Thuente and Friedrich (2008), for example, suggest that “collaboration directly impacts patient outcomes” (p. 43); however, they also suggest that collaboration directly impacts patient outcomes; they also state that “collaboration can take place only when hierarchy is not present” (p. 43). The literature supports the existence of hierarchies and turf wars among CNMs and physicians (D’Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, & Fleming, 2010; Goodman, 2007; Hastie & Fahy, 2011; Keating & Fleming, 2009; Kennedy & Lyndon, 2008, Lane, 2012; Reiger & Lane, 2009). Nevertheless, the findings of the current study do not support Thuente and Friedrich’s position that collaboration and hierarchies are mutually exclusive. In fact, study findings indicate that

while CNMs were not in favor of hierarchies, they had learned to *get along* with their physician colleagues inside hierarchical medical systems. Thus, collaboration can and does take place in spite of difficult relationships and medical hegemony — but how?

The CNM Perception Study revealed a BSP in which CNMs resolve the problem of behaving collaboratively with physicians in U.S. hospitals. The Merriam-Webster Dictionary defines a *process* as a series of actions to achieve an end (Retrieved 11/15/12 from: <http://www.merriam-webster.com/dictionary/process>). Thus, a BSP describes a series of social actions aimed at achieving an end. Participants in the current study described a series of actions, *holding*, *adjusting*, and *releasing*, which they used to achieve the end of *getting along*. The data provided definitions which allowed for the formulation of hypotheses and the *substantive theory* of *getting along*. The *substantive theory* explains and predicts that CNMs and physicians have to *get along* to work collaboratively.

Holding, the first subcategory of the BSP, had a single property, *independent CNM guardianship*. *Independent CNM guardianship* had one major condition and several expectations. The study findings revealed that during *independent CNM guardianship*, the physician had to meet the condition of: *Be ready if I need you*. Furthermore, the CNMs expected the physician to: *Leave me alone*, *Don't come [if I don't call]*, and *Come when I call*, depending on the patient's laboring status.

The CNMs perceived themselves as their patient's guardian whose duty it was to protect the best medical interests of the laboring patient. Fahey and Parratt (2006) also use the term midwifery guardianship to mean: "midwives use[ing] midwifery guardianship to create and maintain the ideal birth territory" (p. 45). Fahey and Parratt

suggest that the best maternity outcomes occur when the conditions necessary for midwifery guardianship involve the patient's right to choose the environment in which to give birth. Fahey and Parratt's description of midwifery guardianship is similar to the *independent CNM guardianship* described in the current study, although the current study findings revealed the CNMs had one condition and three expectations of *independent CNM guardianship*. The CNMs believed the condition and expectations were necessary to *getting along* during the *independent CNM guardianship* phase or outcome. The condition revealed in the present study was based on the CNM's perception of the physician as their resource, to be called upon as needed; therefore, during *independent CNM guardianship* the physician should *be ready if needed*. *Be ready if needed*, was usually coupled with any or all of the three expectations. For example, the CNM expected the physician to be available and

- to trust her enough, while she cared for her patient; *to leave her alone*,
- not intrude while she cared for her patient, *don't come [if I don't call]*,
- to be ready to *come when I call*.

The CNMs perceived *Don't come [if I don't call]* as particularly important to *getting along*. When physicians intruded during the *independent CNM guardianship*, the CNMs believed the physicians were not enabling the process of *getting along*. The CNM expected the physician to participate in her patient's care by invitation only. The final condition was the CNMs' expectation that the physician would trust her to know when she needed help and therefore would *come when she called*. If these condition and expectations were met, the CNM's perceived they were *getting along* with their physician colleagues.

The précis of *independent CNM guardianship* was that when an uncomplicated, laboring patient was admitted to the hospital, the CNM identified the patient as “my patient” and viewed herself as responsible for the care of that patient. When the patient’s condition remained uncomplicated throughout the hospital course, movement in the BSP ceased, and *independent CNM guardianship* became the *outcome*. On the other hand, if the patient’s condition changed, it brought about movement in the BSP, and *independent CNM guardianship* became a *phase*. The *phase* of *independent CNM guardianship* could move to the next category: *adjusting*. *Adjusting* presented the CNMs with new challenges for *getting along*. *Adjusting* happened when the CNMs determined the physician’s unique capabilities might be required to assure the continued well-being of the patient. The amount of physician involvement was determined by the patient’s condition and ranged from informal and peripheral to formal and central. *Checking-in*, *consulting*, and/or *merging* were possible *outcomes* or *phases* in the *adjusting* category.

At least two of the *outcomes* or *phases*, *consulting* and *merging* have been broadly discussed in the extant literature as *consultation* and *collaboration* (Skinner & Foureur, 2010). In fact, the American Congress of Obstetricians and Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM) have issued a joint statement which said, in part, “CNMs and physicians should concur on clear mechanisms for consultation, collaboration, and referral” (Retrieved from: http://www.midwife.org/siteFiles/position/Joint_Statement_05.pdf). However, prior to the CNM Perception Study, no studies had addressed the specific mechanisms or interacting elements involved in *consultation*, *collaboration*, and *referral*.

The present study fills this gap in the literature by identifying the machinery of consultation and collaboration which are addressed as the *adjusting* category. The first possible *outcome* or *phase* of the *adjusting* category was *checking-in*, and it was the most informal and peripheral involvement of the physician. *Checking-in* entailed an informal conversation between CNM and the physician regarding a particular patient with an uncomplicated laboring status. This type of collegial exchange appeared to be one way in which the CNMs perceived they were *getting along* with their physician colleagues. It was possible for movement in the BSP to stop if the patient's condition remained uncomplicated so that *checking-in* became the *outcome*. When the patient's condition changed and continued to require *adjusting*, then *checking-in* became a *phase*.

The next *phase* or *outcome* of *adjusting* was *consulting*, which was a more formal *phase* or *outcome* of *adjusting*. Consistent with other *phases* and *outcomes*, *consulting* occurred when the CNMs' perceived that the patient's condition might require more formal involvement of the physician. In other words, *consulting* was a formal request for an expert opinion from the physician. *Consulting*, also, was sequential. First, the CNM would report important information regarding the patient's laboring status to the physician. Second, the CNM would inform the physician what actions she had taken to treat the patient's condition and what resulted from those actions. Third, the CNM would inform the physician of her plan for the patient's continued care. Two possible consequences resulted from *consulting*. The physician either agreed with the CNMs plan of care or agreed but with additional recommendations. Both consequences of *consulting* became the *outcome* within the *adjusting* category for as long as the patient's condition remained unchanged. If the patient became more high-risk and the CNM needed

additional physician input, movement in the BSP occurred and *consulting* became a *phase*. CNMs believed *consulting* was a more formal involvement of the physician and important to *getting along*, especially if the patient's condition required further physician involvement. Should the patient's condition continue to change, movement in the BSP could lead to the next possible *outcome* or *phase: merging*. *Merging* reflects a concept referred to in the extant literature as collaborating (Skinner & Foureur, 2010). *Merging* was a time when CNMs significantly valued *getting along* with physicians since they would join forces to provide the best possible outcome for the patient. *Merging*, the unique skills of the CNM with the unique skills of the physician, resulting in team guardianship of the patient's care; the patient became "our patient." *Merging*, required a spirit of harmonious collaboration. The literature supports the idea that collaboration plays an important role in eliminating patient care errors and achieving positive health outcomes (Thuente & Friedrich, 2008). Several times throughout the study CNMs indicated a reluctance to *merge* if they had a history of not *getting along* with a particular physician colleague. While not part of the current study, it may be that not *getting along* could negatively impact patient care outcomes.

Merging was the *outcome* if the patient's condition remained unchanged throughout the remainder of the hospital course. *Merging* also could be the last *phase* of the *adjusting* category before moving to the final BSP category, *releasing*. *Releasing* occurred when the patient's status went beyond the CNM's scope of practice and required the unique skills of the physician, the patient then became "their [the physician's] patient." *Releasing* reflects what the literature refers to as transferring care or referral to physician care. *Releasing* was the final category of the BSP.

The *substantive theory* of *getting along* reflects the *core category*, which was the CNM's *main concern*. The *core category* relates to each of the sub categories of the BSP. The CNMs perceived behaving collaboratively as problematic and in order to resolve *behaving collaboratively*, the CNMs used the BSP of *holding*, *adjusting*, and *releasing* to resolve the *main concern* of *getting along*. The *substantive theory* of *getting along* explains and predicts how the CNMs in the current study resolved behaving collaboratively with physicians in U.S. hospitals.

The extant literature is replete with discussions of what collaboration in healthcare should be: collaboration should involve a shared goal, it should impact healthcare economics, allow health care providers to function at the highest level of their training, and involve mutual trust and respect between collaborators (D'Amour, Videla, Rodriguez, & Beaulieu, 2005). Additionally, the literature supports the idea that collaboration should be nonhierarchical (Thuente & Friedrich, 2008). The current study found that, even within a hierarchical system, CNMs were able to *behave collaboratively* and *get along* with their physician colleagues.

CNMs and physicians have a common shared goal of providing every patient with the best possible maternity outcome (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Downe, Finlayson, & Fleming, 2010). Their sharing a common goal is not disputed in the literature or in the current study. The literature also indicates that in spite of sharing a common goal, the relationship between CNMs and physicians is complicated due to differing philosophical viewpoints about how to reach the common goal. The physician views birth as a potentially hazardous event, while the CNM views birth as a normal physiologic event (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, &

Fleming, 2010; Goodman, 2007; Hastie & Fahey, 2011; Keating & Fleming, 2009; Kennedy & Lyndon, 2008, Lane, 2012; Reiger & Lane, 2009). Unfortunately, simply having a shared common goal does not make collaboration what it should be. In order to *behave collaboratively* and *get along* the gap between the differing philosophies had to be negotiated.

Economic expectations for collaboration should include healthcare provider efficiency. In fact, some authors have suggested that CNMs may be the solution for reining in the staggering costs of maternity care in the U.S. (Raisler, 2000). When all healthcare providers function at the highest level of their training, duplication of effort occurs less frequently, as do errors, unnecessary interventions, and unnecessary expenses. Currently, medical hegemony in maternity healthcare has marginalized the work of CNMs (Goodman, 2006). Unfortunately, healthcare has yet to recognize that a consequence of the marginalization of midwifery is the marginalization of the physician providing maternity care to low-risk women. Why are physicians doing the work of the CNM? Physicians doing the work of the CNM are not performing at the highest level of their own training, resulting in costly medicalized birth, even though the majority of women and their newborns are healthy, the costs of maternity care are already staggering (Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012). Collaboration is held hostage and CNMs are unable to reduce healthcare costs (Downe, Finlayson, & Fleming, 2010; Goodman, 2007; Johantgen, Fountain, Zangaro, Newhouse, Hutt, & White, 2012). If inter-professional collaboration is identified as crucial to the development of quality cost effective healthcare systems (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Thuente & Friedrich, 2008), then the findings of the current study may contribute to

decreasing the costs of maternity care by calling for the most appropriate healthcare provider.

Further expectations of collaboration, according to the literature, is that collaboration is described as that which should be based on mutual respect and trust (D'Amour, Videla, Rodriguez, & Beaulieu 2005; Miller, 1977). Nevertheless, D'Amour et al. suggest that it is "...unrealistic to think that simply bringing professionals together will lead to collaboration, or mutual trust and respect. Since professionals have to trust each other before collaborative processes can be established, there is a wide range of human dynamics that need to be developed within a team" (p. 126). Yet CNMs and physicians are expected to work together with the unsubstantiated expectation that they will collaborate. One of the human dynamics identified in the current study was that the CNMs' perceptions that trust and respect involved both a shared history of working together and involved a constant negotiation process. The CNMs believed that mutual trust and respect had to be earned over and over again. So while the literature and the current study agree that collaboration should be based on mutual trust and respect, future grounded theory studies are needed to investigate the BSP of trust and respect among collaborative healthcare team members.

The literature also purports that in addition to issues of mutual trust and respect, collaboration should be equitable and nonhierarchical (D'Amour, Videla, Rodriguez, & Beaulieu, 2005; Down, Finlayson, & Fleming, 2010; Goodman, 2007; Hastie & Fahey, 2011; Keating & Fleming, 2009; Kennedy & Lyndon, 2008, Lane, 2012; Miller 1997; Reiger & Lane, 2009). Although each of the participants in the current study recognized inequities in pay, power, trust, respect, and the imbalance of hierarchies in U.S.

healthcare systems exist, these inequities were not the CNMs' main concern. Moreover, the study findings revealed, that while CNMs do not endorse inequities, CNMs have learned to work with physicians in U.S. hospitals in spite of medical hegemony and a patriarchal healthcare system.

The current study findings break new ground through the discovery of a BSP through which CNMs resolve their main concern of *getting along* through a process of *behaving collaboratively* as they work with physicians in U.S. hospitals. The emphasis of a BSP is on process. The discovery of the *process* of collaborating makes the current study findings meaningful and relevant. Basic social processes, such as *behaving collaboratively*, are systematic, not rigid, allowing for movement both forward and backward among and between *categories/phases/outcomes*. Although the findings of the present study only apply to one healthcare discipline, further study is needed to determine if the processes of collaborating are similar across disciplines.

UNEXPECTED FINDINGS

Classical grounded theory methodology allows for many unexpected findings as the researcher remains open to the data (Glaser 1978). Unexpected findings are inherent when CGT methodology is utilized. Several surprising findings occurred during the current study. The study also revealed unpredicted methodological insights.

The study arose from the researcher' curiosity about how CNMs and physicians collaborate in U.S. hospitals. The review of the literature made clear the need for further investigation of collaborating. Qualitative research methods appeared particularly suited to fill the gap in the literature on understanding the process of collaboration. One of the goals of Glaser's classical grounded theory is to discover a basic social process through

which substantive theory might be generated. As a result, the researcher began studying Glaser's CGT methodology by reading his numerous books and participating in a Grounded Theory Institute seminar, conducted by Glaser. Classical grounded theory methodology emerged as the perfect methodological fit for answering the research question, "How does the CNM perceive her collaborative role with physicians in U.S. hospitals?"

It was surprising to find that the main concern for CNMs who behave collaboratively with physicians in U.S. hospitals was *getting along*. Even though *getting along* was at the heart of the complexities of *behaving collaboratively*, it was also surprising to discover a BSP that met Glaser's criteria of having clear *phases* and/or *outcomes* which *changed over time* and had *conditions and consequences*. On the other hand, it may not be surprising that the *behaving collaboratively* BSP (*holding, adjusting and releasing*) was driven by the patient's condition or that the CNM and physician had a shared common goal of good patient outcomes, but it was surprising to find that the BSP was a constant series of quick and sometimes intense negotiations. On a moment-to-moment basis, the CNMs were capable of negotiating *independent* care of patients, or negotiating the potential *merging* of complementary capabilities of the CNM and the physician, or negotiating a *release* of the patient's care to the physician.

Unexpected findings were particularly important in the first category: *holding*, and can be attributed to the iterative nature of classical grounded theory methodology. The researcher initially believed that there were two possible *phases* or *outcomes* in *holding*: *independent CNM guardianship* and *resourcing*. It was thought that *resourcing* consisted of: *be ready if I need you, leave me alone, don't come [if I don't call], and*

come when I call. However, *resourcing* did not hold together as a separate property from *independent CNM guardianship*. In other words, *resourcing* was not a property of *holding*; instead *resourcing* was a set of the condition and three expectations of *independent CNM guardianship*. Thus, in the current study provides an example of how a classical grounded theory will not hold together if it is invented by researcher preconceptions (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012).

Certified nurse midwives in the U.S. have adapted to the constraints of market-driven, medically-dominated healthcare (Goodman, 2007). This is not to say that CNMs support the inequities and constraints of a society whose healthcare is overshadowed by medicine; instead CNMs have learned to make *behaving collaboratively* work. In fact, the study revealed that there is an identifiable, teachable *behaving collaboratively* process that could work within the current U.S. healthcare system. The discovery of a teachable process was unexpected but may have implications for the future education of healthcare providers.

The study also provided unexpected methodological insights. The first unexpected finding was that the investigator had to learn “Glaser-speak” as a first step in order to understand Glaser’s classical grounded theory. At first glance, “Glaser-speak” appeared to be complicated and difficult to understand, but as the researcher began using the methodology, Glaser’s phrases became utilitarian as building blocks for understanding the methodology. Glaser uses phrases like: “doing grounded theory,” “being open to the data,” “the main concern,” “a problematic behavior easily recognizable to those who experience it,” and many others (Glaser, 1967, 1978, 1992, 1996, 1998, 2006, & 2012; B. Glaser, personal communication, May 18, 2012). “Glaser-speak” required learning

Glaser's language, using terms as he defined them, not as the terms might be used in common language. Nonetheless, "Glaser-speak" provided the foundation for learning CGT methodology and becoming a classical grounded theorist.

The classical grounded theorist learns to tolerate the initial confusion that comes from not knowing what the data is revealing. By persevering in the utilization of CGT, patterns emerge, and consequently the classical grounded theorist is delighted to learn what the data reveals and to discover unexpected findings and methodological insights that strengthened the study and researcher's skill (Glaser, 1978). Utilizing CGT methodology had the unexpected finding that in *doing classical grounded theory*, the classical grounded theorist broadens her understanding of how to use the methodology; doing it it helps one learn "how." For example, the researcher was intently concerned with what the data was saying; prejudices and biases went away as a result of that singular focus. Free from bias, this classical grounded theorist, used CGT methodology to become centered and open to the discovery of recurring patterns within the data. Moreover, as Glaser (1967, 1978, 1992, 1996, 1998, 2006, & 2012) explains, it is through concentrating on recurring patterns in the data, the classical grounded theory researcher becomes naturally free from prejudices and/or biases.

STUDY STRENGTHS

The strengths of the study included the research design, the use of an innovative method of data collection, the data analysis, and the results. The study design sampling techniques were one of its strengths. The participants in the current study were CNMs who work with physicians in U.S. hospitals. The study design and data collection method produced a geographically diverse sample which was representative of the demographics

of national membership of the American College of Nurse-Midwives (ACNM). The study design proved useful for breaking new ground in the substantive area of collaboration in healthcare where the concepts consistently have been well defined, but processes of *behaving collaboratively* have not been identified. Moreover, the study design and sampling technique can be modified across healthcare disciplines for future research in similar or different substantive areas.

The idea for the research design began early in the dissertation process, as did the idea to conduct online synchronous interviews. The data collection method allowed the researcher to obtain a sample of CNMs with characteristics similar to the characteristics of the CNM membership of the national organization (ACNM). An additional benefit of the data collection approach was it was inexpensive and not constrained by geography. Furthermore, most participants indicated they enjoyed the synchronous online interview setting. The researcher believes she and the participants shared an intimate and relaxed feeling when chatting online which allowed the participants to be genuinely candid and expressive. It is unlikely that another method of data collection would have yielded such rich data combined with such geographic diversity.

Data collection using online synchronous interviews was a major strength of the current study and should be considered as a solid data collection method by future researchers. In addition to being an effective approach to data collection, synchronous online interviews were uniquely suited to CGT methodology. Classical grounded theory methodology required being immersed in the data moving amongst data collection and data analysis, new data, and further data analysis. The synchronous online interviews allowed the classical grounded theorist to collect and analyze data before collecting

additional data. In this way, synchronous online interviews are a good fit for the iterative processes of CGT methodology.

It is clear to this researcher that the study would not have resulted in the same findings had another qualitative methodology been employed. The evidence for such a statement arises directly from the discovery of a *basic social process* and the *substantive theory*. CNMs, in order to address their main concern of *getting along*, used the *behaving collaboratively BSP* constituted by *holding*, *adjusting*, and *releasing* to resolve the problem of behaving collaboratively with physicians in U.S. hospitals. Other qualitative methods may have resulted in confirming the extant literature but would not have resulted in a new contribution to the literature through the identification of the *behaving collaboratively BSP* and the *substantive theory of getting along*.

STUDY LIMITATIONS

The current study is limited by sample size and characteristics, dissertation requirements, and limitations of the researcher. A well known limitation of qualitative research is generalizability. Qualitative research is not generalizable because it seeks understanding; qualitative research does not seek proof (Glaser, 1978). Consequently, generalizability of findings from the current study is limited by sample size and characteristics. Nevertheless, the study sample size was appropriate for qualitative research. Demographic characteristics of the 16 CNM study participants, who represented 13 U.S. states, were comparable to the American College of Nurses Midwives (ACNM) national averages. All sixteen participants were members of the ACNM professional organization and were CNMs who work with physicians in U.S. hospitals. Additionally,

each participant had the skills necessary to participate in a synchronous online interview. Therefore, study findings are limited to the perspectives of this circumscribed group.

Another limitation of the current study is related to the choice of CGT methodology. A researcher who is a student of Glaser's and wishes to be a purist in the CGT will soon discover that most universities require a pre-research literature review. Glaser's (1998) position on the pre-research literature review is that "a pre-research review of the literature is inimical to generating classical grounded theory" (p. 67). A classical grounded theory study has strong dicta related to the review of the literature:

- a. do not do a literature review in the substantive area and related areas where the research is to be done, and
- b. when grounded theory is nearly completed during the sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison.

The aim of Glaser's (1998) literature dicta is to keep the grounded theory researcher as free and open as possible to the discovery and emergence of concepts, problems, and interpretations from the data. The pre-research review of the literature for this study served little purpose other than to support the need for the study. The literature tends to support the idea of collaboration but tells us little about how collaboration works. The literature became clearer when post-research findings began to emerge. After data analysis, the literature became much more relevant and meaningful.

Glaser's (1998) position is that in a CGT study the literature should be discovered in the same way theory is discovered, and "delaying the literature review is not neglect or anti-scholarship" (pp. 68-69). Once the researcher has captured the conceptual discoveries within the data she returns to the literature to integrate it into her theory.

The author gently recommends that future students interested in a purist approach to Glaser's CGT be given the option of conducting the review of the literature post data collection and analysis. By allowing this non-traditional review of the literature, the classical grounded theorist would be free to use Barney Glaser's CGT methodology and free from the confusion of concepts, definitions, and hypotheses in the extant literature.

Finally, the findings from the current study are limited by the researcher's experiences. The researcher acknowledges her inexperience with CGT methodology; however, inexperience was overcome through the mentorship of Carolyn Phillips, Ph.D., Barney Glaser, Ph.D., and other CGT fellows. Additionally, the researcher acknowledges she is an experienced CNM who works collaboratively with physicians in a large university hospital in Southeast Texas. Nevertheless, safeguards against bias in the current study were maintained through the use of a mentor who is not a CNM and the choice of CGT methodology.

IMPLICATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

The current study makes a novel contribution to the extant literature through the discovery of the *behaving collaboratively BSP* and generation of the *substantive theory of getting along*. The study findings have implications for the improvement of clinical practice, for the education of future healthcare providers, and for future research.

The current study findings made a novel contribution to previous research through the generation of the *substantive theory of getting along*, from the perspective of the CNM who works collaboratively with physicians in U.S. hospitals. Substantive theory is important because it fits the real world, it predicts and explains, it is relevant to the people concerned, and it is modifiable to a variety of conditions (Glaser, 1978). Clearly,

this study only reveals one half of the perspective of the collaborative partnership between CNMs and physicians. The study explored collaborating from the CNMs' perspective but did not include how physicians perceive their collaborative roles with CNMs in U.S. hospitals. The current study design could be modified to include physician perspectives. It would then be possible to compare the physician's perception to the CNM's perception. Consequently, the current research has provided a potential platform for other scientific inquiry, across disciplines, and has implications for the development of formal theory.

Future research is needed to determine if the *behaving collaboratively BSP* with its phases or outcomes of *holding*, *adjusting*, and *releasing* are applicable only to CNMs and physicians who work in U.S. hospitals to provide collaborative maternity healthcare, or if the processes cross disciplines. Is *getting along* with their collaborative physicians a shared *main concern* of all advanced nurse practitioners (APNs), regardless of specialty? Do all APNs resolve the problem of behaving collaboratively with physicians through the *behaving collaboratively BSP*? Such research would not only have implications for *formal grounded theory* but could also have implications for clinical practice. For example, if future research discovers universality in the *behaving collaboratively basic social processes* of APNs collaborating with physicians, there are implications for the future education of nurses, physicians, and other healthcare providers. Future healthcare providers could be taught how to *get along* in a collaborative environment, replacing the current educational process that tends to simply expect healthcare providers to collaborate, without teaching collaboration as a skill.

CONCLUSION

This study provides new information about patterns of *behaving collaboratively* in real life clinical practice settings. The study uniquely contributes to the current body of literature by describing the basic social processes of behaving collaboratively from the viewpoint of CNMs who work with physicians in U.S. hospitals to provide maternity care. To date, no other studies have given CNMs a voice to describe their main concern of *getting along* with their physician colleagues. No other studies have identified the basic social process through which CNMs resolve their main concern to reach the goal they share with their physician colleagues: optimal maternal and neonatal patient outcomes.

The study findings suggest expectations for collaboration in healthcare are obtainable, at least in maternity healthcare. If healthcare providers can be taught how to *behave collaboratively* and *get along*, reaching a shared common goal may be more possible, roles may become clearer, philosophical differences may become complementary instead of contentious and mutual trust and respect can become a natural consequence of *getting along*.

Appendix A: IRB Approval



OFFICE OF RESEARCH SUBJECT PROTECTIONS
Institutional Review Board

19-Apr-2011

MEMORANDUM

TO: Carolyn Phillips, RN, PhD/Susan Nilsen, CNM, MSN
OB/GYN 0587

A handwritten signature in cursive script, appearing to read 'Richard Rupp', is written over the printed name.

FROM: Richard Rupp, MD
Director
Institutional Review Board 0158

SUBJECT: Expedited Review, Human Subjects

Project Director: Carolyn Phillips, RN, PhD/Susan Nilsen, CNM, MSN IRB #11-071
Project Title: Midwives' Perceived Role in Collaborative Practice

Under the Institutional Review Board's policies and procedures for reviewing protocols by an expedited review process, your project referenced above was **approved** on April 4, 2011. I am, therefore, pleased to inform you that you may proceed with this project immediately.

This project will require **annual** review by the IRB and will expire on March 31, 2012. **Research that has not received approval for continuation by this date may not continue past midnight of the expiration date.**

Project Directors of approved projects are responsible for reporting to the Institutional Review Board any unanticipated problems involving risks to subjects or others (includes adverse events) observed during the conduct of the project as well as any severe or serious side effects whether anticipated or unanticipated. If the adverse events were unanticipated or death has occurred, the adverse event must be reported to the IRB within 24 hours.

Should your project require modification which alters the risk to the subject or the method of obtaining informed consent (if applicable), the project must be reevaluated by the Institutional Review Board before the modification is initiated. Modifications to procedures or the project to remove an immediate hazard to subjects may be made prior to IRB review.

If applicable to the study, completed subject consents should be maintained in the designated location for at least three years after the termination of the project. In order to be in compliance with the requirements of the regulations, a copy of the completed consent document must be provided to the subject and for more than minimal risk studies, a "Notice of Research Participation" form must be filed in each subjects' medical record.

Appendix A: IRB Approval

Waiver of the requirement for obtaining written documentation of informed consent was approved after determining that either 1) the consent form would be the only record linking the subject and the research and the principal risk would be loss of confidentiality, or 2) the research presents no more than minimal risk to the subjects and involves no procedures for which written consent is normally required outside the research context. It was also determined that continuing review of this protocol did not have to be accomplished more often than annually.

This project is approved for completion of an on-line interview. All data will be coded to protect confidentiality.

RR/ah

Appendix B: ACNM Study Approval

Kerri D. Schuiling, PhD, CNM, NP-BC, FACNM
ACNM
8403 Colesville Road Ste 1550
Silver Spring, MD
May 19, 2011

Susan Nilsen
Director, RMCHP Inpatient Services
The University of Texas Medical Branch
301 University Boulevard
Galveston, TX 77555-0587

Dear Ms. Nilsen:

We have received your correspondence about your research study: "Midwives' Perceived Role in Collaborative Practice" and your request to access ACNM members for their participation in the study. Thank you for forwarding the pertinent documents to the ACNM office. The purpose in requesting these documents for the ACNM files is to ensure that the rights of ACNM members as research participants will be adequately safeguarded and that surveys mailed to ACNM members are pertinent to the midwifery profession and practice.

All of the relevant documents have been reviewed and your request is approved. I appreciate the very strong letter of support provided by your faculty advisor.

The general statement that ACNM requires you to use in your letter to CNMs/CMs or solicitation ads/fliers is: "Solicitation of CNM/CM participants for this study has been approved by ACNM".

Also included with this approval to access ACNM members is a document titled: Rights of ACNM Members as Research Subjects, and contact information for our Director of Membership Services, George Hamilton. His email is ghamilton@acnm.org. George will assist you in setting up the email notification to members that you will use to send our members the link to your survey.

Good luck with your study! We look forward to reading about the results of your study.

Sincerely,



Kerri D. Schuiling, PhD, CNM, NP-BC, FACNM
Sr. Staff Researcher
ACNM

Appendix C: Email Invitation to Participate

The following email was sent out by the ACNM to 2500 randomly selected ACNM members:

On 25 January 2012 14:55, <snilsen@utmb.edu> wrote:
Dear ACNM member,

I am looking for CNMs, who attend births in the hospital setting, would like to chat with me about their perceptions of their role in the intrapartum collaborative setting, and would be willing to participate in my doctoral research.

Solicitation of CNM/CM participants for this study has been approved by ACNM.

The CNM Perception Study proposes to describe the CNM's perception of her/his role in collaborative in-patient hospital practice, using a qualitative design & anonymous online interviews. Demographics and open ended interview questions may inform/clarify the role of the CNM in the hospital setting, the role of the CNM in the context of collaboration, add to the educational preparation of new midwives and help direct future healthcare policy.

About Participating:

If you would like more information please visit:
<http://cnmperceptionsstudy.blogspot.com/>

Or please feel free to contact me directly if you would like to schedule a time to participate

PI: Susan L. Nilsen CNM, PhD(c)
University of Texas Medical Branch
snilsen@utmb.edu
midwyfsue@gmail.com

Appendix D: The Blogspot

<http://cnmperceptionsstudy.blogspot.com/>

The CNM Perception Study Proposes to describe the CNM's' perception of her role in collaborative in-patient hospital practice. The study will be using a qualitative design & anonymous synchronous online interviews. Demographics and open ended interview questions may inform/clarify the role of the CNM in the hospital setting, the role of the CNM in the context of collaboration, add to the educational preparation of new midwives and help direct future healthcare policy.

About Participating

PI: Susan L. Nilsen CNM, UTMB Doctoral Student
UTMB Faculty Sponsor: Carolyn Phillips RN, PhD

If you would like to participate, please understand that your participation is voluntary and you may opt out of the study at any time during or after the interview, however you must exercise this option prior to publication of study results. Informed consent will be obtained as part of the interview.

If you would like to participate in The CNMs' Perception Study, first create an anonymous g-mail account. Go to: <http://mail.google.com/mail/help/intl/en/about.html>.

Click on: "Get Started."

1. Use the last name "Participant plus any 4 numbers," for example "Participant 1976."
2. Create your anonymous login name that says nothing about who you are, for example:
 - a. you might choose your favorite number, mine is 3
 - b. choose the name of a flower, for example Susan means lily
 - c. add your favorite color, mine is purple

So my login might look something like this
3lilliepurple@gmail.com

You may then leave your g-mail address in the followers section or email the PI @ midwyfsue@gmail.com or slnilsen@utmb.edu. You may request an interview time or the PI will contact you with available times.

You will determine the length of your interview, though no interview is expected to last more than 30-60 minutes. You will be given information on how to obtain study results.

If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research or you would like more information, you may contact the University of Texas Medical Branch Institutional Review Board Office at 409 266 9475.

Protection of Personal Information

Your interview will be automatically saved to both your address and the PI's address. You can delete your interview and you will be able to see when your interview has been deleted. G-mail does not archive chats. The data from the synchronous sessions will be saved on the PI's password protected computer which will remain secure in the PI's locked office. Each transcript will be saved intact and ALL identifiers will be removed (including the anonymous email address). Should a need arise for hard copies they will be made from a deidentified copy of the transcript and will remain secure in a locked cabinet in the locked office of the PI. ALL forms of data will be destroyed at the study's conclusion.

Solicitation of CNM/CM participants for this study has been approved by ACNM.

Appendix E: Informed Consent

PI types: Hi, I am Susan Nilsen, a full-time/full scope practicing CNM, a doctoral student at the University of Texas Medical Branch and the PI for the CNMs Perception Study. Are you ready to begin?

Participant types: a response.

PI types: I would like to begin with the research purpose and question. I will then discuss the risks and benefits of study participation. You will then have an opportunity to ask any questions, give informed consent and proceed. May I continue?

Participant types: a response.

The purpose of this study is to describe and conceptualize the CNM's perception of her role in a collaborative practice. The research question is: How does the CNM perceive her collaborative role in the hospital?

The *primary risk* to participating in an online synchronous interview is a theoretical threat to confidentiality. Steps to prevent this risk include:

1. You have been given opportunity for anonymity by signing into the online synchronous forum under a pseudonym.
2. You have been encouraged to select a pseudonym that will not provide any traceable information to your actual identity.
3. Your data will be kept confidential and secured on the researcher's password protected computer and destroyed at study's completion.
4. Interview transcripts will be saved on my computer, which is password protected and kept secure.
5. I assure you that your transcripts will be used for research purposes only and will be destroyed at the conclusion of the study.

There are no direct individual *benefits* to participation. It is hoped that your interview combined with the interview of others may inform and clarify the role of the CNM in the hospital setting, the role of the CNM in the context of collaborative practice, add to the educational preparation of midwives, and help direct future healthcare policy.

Do you have any questions?

Participant types: a response.

PI types: Proceeding to the next section indicates your informed consent to participate in the CNM Perception Study. The above information will remain in your transcript and serve as your signature of informed consent.

Please answer the following question by typing "agree" or "decline."

Having been fully informed of the purpose of this research, my rights, and my responsibilities, I agree/decline participation in the CNMs Perceptions Study.

Participant types: agree or decline

Solicitation of CNM/CM participants for this study has been approved by ACNM

Appendix F: Demographic Questions

Please feel free to use emoticons with your answers.
Are you male or female?
What is your age?
How do you describe your race/ethnicity: White/Non-Hispanic Black/Non-hispanic Hispanic White Hispanic Black American Indian/Alaskan Native Asian/Pacific Islander All other?
In what city/state do you live?
In which state(s) are you currently licensed?
Please describe you post high school education?
Do you have other degrees or certifications?
How many years have you been practicing midwifery?
In which of the following settings have you worked? Home birth Free Standing Birth Center (CNM managed with or without back up) In Hospital Birth Center In Hospital Combined Unit (MDs & CNMs) Private Practice (Physician managed)
What did you do prior to becoming a midwife?
Is the hospital in which you work publically or privately owned?
Is your hospital an academic or teaching institution?

Appendix G: Semi-structured Interview Questions

Can you give me a brief description of the hospital practice in which you work?
Is the practice in which you work collaborative?
What would make it MORE collaborative?
Would you describe for me the IDEAL collaborative practice?
What is it like being a midwife in your hospital?
Is there more?
What else?
Can you tell me a story about when collaborating went well?
What about that story would you identify as collaborative?
Any chance you have a "never again" story, one that you might tell me and when you are finished with the story you would say, "I hope that NEVER happens to me again?"
What about that story is NOT collaborative?
What about collaboration is most important to you?
Who do you think are the collaborative "players" in your practice?
What is your role in the context of these 'players'?"
What about collaboration is most important to you?
Is there anything else I should ask you about collaboration?
Is there anything else you think I should know about your role in your practice?
Are you interested in seeing the results of this study?
If so, to what email address would you like me to send the study results?

If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the University of Texas Medical Branch Institutional Review Board Office, at (409) 266-9475.

Do You Deliver Well With Others?



Who: CNMs WHO ATTEND BIRTHS IN A HOSPITAL

- ✓ a CNM working in a collaborative hospital practice
- ✓ able to speak, read, and write in English
- ✓ access to a computer,
- ✓ has computer skills for the online interview. what:
Anonymous online interview with:
✓ Susan L. Nilsen CNM, MSN, PhD Student
snilsen@utmb.edu

What is your perception of your role in collaborative practice?

If you are interested in "having a say" about your
professional practice?

For more information: Click on the following link:

<http://cnmperceptionsstudy.blogspot.com/>

**Solicitation of CNM/CM participants for this study has been approved by ACNM
All study procedures have been approved by the University of Texas Medical
Branch Institutional Review Board**

Appendix I: Email Request to Schedule Interview Appointment

Dear Study Participant,

Thank you for your earlier interest in the CNM Perception Study. I would like to ask if you are still interested in participating in the study and possibly scheduling a convenient date and time for your online synchronous interview

I look forward to your response.

Respectfully,
Susan Nilsen P.I. CNM Perception Study

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Vita

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Current Professional Position

Director, Inpatient Services at The University of Texas Medical Branch
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Since 2007

Education

University of Texas Medical Branch Ph.D., 2013
Case Western Reserve University MSN, 2003
University of Texas at Arlington BSN, 1993
University of Texas at Austin BS, 1980

Membership in Scientific Societies/Professional Organizations

American College of Nurse Midwives
American Congress of Obstetricians & Gynecologists
Sigma Theta Tau International Honor Society of Nursing

Licensure/Board Certifications

Registered Advanced Practice Nurse with Prescriptive Authority in the State of Texas
RN # 593654
American College of Nurse Midwives
CNM # 8267

Previous Work Experience

Austin Area Birthing Center • Austin, TX 78759 • 3/15/05-10/31/2006
Position Held: Staff CNM

Central Texas College • 6200 W. Central Expswy, Killeen, TX 76549 • 9/1/05-1/07
Position Held: Nursing School Faculty for OB Nursing

Carl R. Darnall Army Community Hospital, Fort Hood, TX • 6/1998-11/2004

Position Held: Staff CNM

Posters

Nilsen, S., Co-presenter: UTMB Academy of Master Teachers Education Symposium, 4th Annual, May 20, 2011, Galveston, TX. Poster Title: Does simulation training impact student knowledge & confidence for female breast & pelvic exam?

Nilsen, S., Presenter: 59th Annual Clinical Meeting (ACM) of the American College of Obstetricians and Gynecologists (ACOG), May 2, 2011, Washington, D.C.
Poster Title: Collaborative Obstetrical Care: A University Model for Success

Nilsen, S., Presenter: American College of Nurse-Midwives (ACNM), 56th Annual Meeting & Exhibition, May 23-28, 2011, San Antonio, Texas
Poster Title: Collaborative obstetrical care: A university Model for Success

Nilsen, S., Presenter: 60th Annual Clinical Meeting (ACM) of the American College of Obstetricians and Gynecologists (ACOG), May, 7, 2012, San Diego, California.
Poster Title: Does simulation training impact student knowledge & confidence for female breast & pelvic exam?

Podium Presentations

Nilsen S., (2013, February). Collaboration in Obstetrics 30th, Annual Perinatal Nursing Symposium, Reeling in New Life Kaleidoscope. Galveston, TX.

Nilsen, S., (2011, October). Perceptions of CNMs in Collaborative Practice, The Gathering of Midwives Annual Meeting 2011, Galveston, TX.

Nilsen, S., Co-presenter: 2012 CREOG & APGO Annual Meeting. "Embracing transitions in healthcare: Educating for tomorrow, today!" March 7-10, 2012, Orlando, FL

Research Experience

1 Project Name: SISTERS in Labor

Principle Investigator/Project Director: Susan Nilsen, CNM, MSN

Duration: April, 2009 - April 2011

Research Purpose: This study was a retrospective chart review of patients entering intrapartum hospital care to the UTMB Midwifery Service. The patients were selected from 5 years of midwifery delivery logs. Two groups were identified, the group of patients who remained in the CNM service and the group who were transferred to physician service. The antepartum and intrapartum variables from the two groups were compared. One goal of the study was to identify variables that would allow for the development of a Safe Intrapartum Scoring Tool for the Evaluation of Risks in Labor.

#2 Project Name: Does simulation training impact student knowledge & confidence for female breast & pelvic exam?

Investigators: Jain,S., Fox, K., Van den berg, P., Nilsen, S., Olson, G., Karnath, B., and Szauter, K. September, 2010 – May, 2011

Research Purpose:

- 1) To determine if use of simulators improves clinical skills, confidence level and understanding of UTMB's 2nd year medical students, when examining the standard patient (paid human subject) during their Gynecological Teaching Associates session.
- 2) To determine if simulation workshop improved professional behavior and overall preparation of the 2nd year medical students for the GTA session as assessed by the standard patient.

#3. Project Name: How does the CNM perceive her collaborative role in the hospital?

Investigator: Nilsen, Susan

March 6, 2011- March 16, 2012

Research Purpose:

- 1) To understand the process of collaboration from the CNM's perspective.
- 2) To generate a grounded theory related to the processes of collaboration from the CNM's perspective as they work with physicians in hospitals in the U.S.

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This dissertation was typed by Susan L. Nilsen.