PRESERVATIVE MANAGING WHILE SPIRALLING DOWNWARD: THE
EXPERIENCES OF NURSES WHO CARE FOR WOMEN IN LABOUR
AND DELIVERY IN A TIME OF HOSPITAL RESTRUCTURING

By

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A thesis submitted in conformity with the requirements
for the degree of Master of Science
Graduate Department of Nursing Science
University of Toronto

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ABSTRACT

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Grounded theory methodology elicited 8 subjects' experience. During a period of restructuring, preservative managing was identified as the core category which subsumed six categories. They were (a) comparing and contrasting satisfaction—labour and delivery versus other clinical areas, dampening of satisfaction, (b) living with political forces—leaving politics at the door, living with fear/insecurity, mitigating/adapting to deleterious forces of politics, (c) maintaining safety as top priority—regarding safety as non-negotiable, being vigilant, relying on technology, giving safe care to all patients, (d) being challenged—living with unpredictability, nursing complex patients, making the difficult patient less difficult, maintaining quality care, (e) providing support—bringing confidence into the room, advocating for patient versus physician, informing/educating childbearing couple, being there/not being there, being the person the patient needs you to be, providing indirect support, (f) engaging in professional relationships—working as a team, supporting/not supporting colleagues, not being supported by others, and enjoying autonomy.
This thesis would not be possible if not for generosity, dedication, and kindness of several people. First, I would like to thank the nurses who participated in this study. They devoted their time, thoughts, and in several instances, kind hospitality that I will be forever grateful in receiving. I am indebted to you for your good will and valuable information.

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BACKGROUND TO THE PROBLEM

Childbearing is one of the most significant events in a woman's life and it usually occurs in a hospital. In hospital, intrapartum nurses provide professional support to childbearing women in labour and delivery. Intrapartum nurses frequently apply medical technology that they have uncritically integrated into their obstetrical nursing practice (Sandelowski, 1988). Canadian obstetrical nurses practice in a hospital environment in which the rate of caesarean sections is 18% (Statistics Canada, 1994), the incidence of instrumental delivery is 12.4% (Statistics Canada, 1994), and fetal monitoring is widely used (Davies et al., 1993). Intrapartum nurses have been observed to perform more technical tasks than supportive nursing actions (Gagnon & Waghorn, 1996; McNiven, Hodnett, & O'Brien-Pallas, 1992). Nurses carry out tasks of a technical nature and the nurses' time is taken up by fetal monitoring, caring for the equipment, and assisting the physician.

Although there is evidence that Canadian women were "somewhat satisfied" with their obstetrical care (Obstetrics '87, 1987) a decade ago, women have continuously reported dissatisfaction with the amount and quality of support they receive from nurses during labour and delivery (Brown & Lumley, 1994; Field, 1987; Kirke, 1980; Lesser & Keane, 1956; Shields, 1978). Dissatisfaction with emotional and psychological support coupled with substantial amounts of technical interventions in a hospital environment may partially account for the slight shift in choice by women in maternity care providers, that is, from nurses and physicians in hospitals to midwives in birthing centres and at home (Ontario Interim Council on Midwifery, 1993).

Caregiver support has repeatedly been shown to have positive effects on childbirth outcomes (Hodnett, 1999). Furthermore, research has shown that the qualities of the intrapartum nurse and the care she provides affects the caesarean section rate (Radin, Harmon, & Hanson, 1993). Because the quality of intrapartum nursing care affects women's psychological and physical birth
outcomes, it is imperative that we better understand labour and delivery nurses' behaviour in the changing context where they provide care.

Background Literature

The role of the intrapartum nurse was described by obstetrical nurses and childbearing women 40 years ago. Lesser and Keane (1956) conducted an exploratory study in which they interviewed obstetrical nurses at a large New York Hospital. The sample of 37 in Lesser and Keane's (1956) study consisted of one third of the nurses working in antepartum, intrapartum, and post-partum areas employed at this hospital plus 8 nurses involved in obstetrical administration. There was no mention of the specific number of intrapartum nurses interviewed in this sample. The antenatal, postnatal and administrative nurses were allowed to give their views on nursing care during labour and delivery and their views were integrated with the data received from labour and delivery nurses.

The principle investigators carried out “intensive” interviews with this sample of nurses and the areas to be covered during the interview were pre-determined. The protocol covered the following areas: a) concept of patients' needs and goals during the antepartum, intrapartum, and postpartum periods; b) nurse's description of role she plays in the area of obstetrics in which she is currently employed and her conception of the nurse's role where she is not herself employed; c) concept of the role she actually plays and her conception of the ideal role during pregnancy, labour and the puerperium; d) her perceptions of and responsiveness to needs expressed by the patients; e) satisfaction/dissatisfaction concerning the job she has and the functions she performs; f) attitudes towards the patients; and g) feelings concerning current nursing practices in obstetrics. The nurses in Lesser and Keane's study reported that the role during labour and delivery was to provide a safe outcome for the mother and baby, and to organize and co-ordinate the functions of other members of the obstetrical team. Their main source of job
satisfaction was found in being efficient organizers of obstetrical care and they wished to be viewed as dependable allies to the doctor. Although Lesser and Keane (1956) found nurses were aware that women in labour expect them to fulfill roles of support person and co-ordinator of care, they found that performing observational functions took precedence and served as barriers to carrying out supportive functions. No other study was found which investigated the perceptions of obstetrical nurses in regard to caring for women in labour. Furthermore, no study was found in which data were derived from a homogeneous sample, that is, intrapartum nurses.

Over the past 40 years the intrapartum nurse has faced increasing amounts of technology. The caesarean section rate in Canada has increased from 6 percent in 1970 to 18 percent in 1992 (Francome & Savage, 1993; Statistics Canada, 1994). Electronic fetal heart monitoring was developed in 1960s and now has gained widespread use (Grant, 1989). Pain control during labour has changed over the years in which a shift from rectal ether, narcotics and psychoprophylaxis to the increased use of lumbar, epidural analgesia in the 1970s and 1980s occurred (Dickersin, 1989). The intrapartum nurse plays a significant part in the implementation of the above technologies that have evolved over the past several decades.

Lesser and Keane (1956) also conducted “intensive” interviews with 66 childbearing women, antenatally and postnatally, and found that the women expected the nurse would a) provide bodily care, b) be a sustaining presence throughout labour, c) help the women achieve pain relief, d) help assure them of a safe outcome, and e) accept each woman's personal attitude and behaviour during childbirth. Based on the five expectations of nursing functions, outlined in Lesser and Keane's (1956) study, several more recent studies concerning childbearing women and the role of the intrapartum nurse have been conducted (Bond, Keen-Payne & Lucy, 1995; Callister, 1993; Mackey & Lock, 1989; Shields, 1978).
Shields (1978) conducted a descriptive study to identify how well the five expectations of childbearing women outlined in Lesser and Keane's study were met. Using an interview questionnaire designed for the study, she conducted interviews with 80 post-partum women. The data derived from the interviews were placed under seven categories describing care provided by nurses: physical care only, supportive care only, medications only, supportive and physical care, supportive and medications care, physical care and medications, and supportive and physical care and medications. Physical care in this study consisted of taking vital signs including fetal heart rate, timing contractions, perineal shave preparation, giving a bedpan/kidney basin, back rub, positioning a patient and assisting the doctor with equipment. Nursing care with respect to medications was noted if the patient described the nurse as giving any medication or assisting with the administration of an anaesthetic. Supportive care included: helping with breathing exercises, holding her hand, staying with her, encouragement, explanations and providing psychological comfort.

Seventy-two patients described their nursing care in terms of physical care and/or medications, but only 12 patients judged these types of nursing care as the most helpful. Forty-five patients indicated that they received supportive care from nurses. However, supportive care was judged by 44 subjects as the most helpful form of nursing care. It is not known whether or not the subjects who reported a certain type of care as the most helpful actually received that type of care. Hence it would appear that the majority of women in this study reported that they received care that consisted of physical care and/or medications (72 out of 80 subjects), rather than supportive care (45 out of 80), and that childbearing women valued supportive care (whether they received it or not) more than physical care and/or medications.

Some women in Shield's study failed to report supportive nursing care during labour and delivery. Women's perceived absence of supportive care is
given credence by Klein, Gist, Nicholson and Standby's (1981) study in which they actually observed the infrequent demonstrations of supportive care. Utilizing a time sampling method, nurses providing care to 40 primiparous women were observed for one hour when the childbearing woman was found to be 4-5 centimetres dilated and before any analgesic was given or any labour abnormalities were detected. It was found nurses rarely perform supportive behaviours such as touch, presenting comfort items, talking, and modelling breathing. The number of nurses involved in this study, the number of observations made, and who did the observing were not reported.

Using the work-sampling method to gather data on 17 intrapartum Canadian nurses McNiven et al. (1992) recorded 616 observations of intrapartum nurses and reported that intrapartum nurses devote only 9.9% (95% C.I. 0.075 and 0.12) of their time providing supportive care. Supportive care included physical comfort measures, emotional support, instruction and information, and patient advocacy. The remaining 90.1% of the time was spent in activities such as physical assessments, performing or assisting with procedures, documenting care, attendance at meetings, meal breaks and other activities. McNiven et al. (1992) commented that "increases in the amount and complexity of medical technology cannot entirely explain the lack of supportive care measures" (p.6).

More recently, the work-sampling method was utilized in an intrapartum unit of a Canadian hospital which employed 42 nurses (Gagnon & Waghorn, 1996). In this work-sampling study the researchers made 3367 observations and of those observations 206 were deemed supportive, making the percentage of time nurses spent engaging in supportive care 6.1%. Supportive care encompassed the following activities: physical comfort measures (positioning, bathing, changing linen, giving ice chips, touch, assisting with ambulation), emotional support (reassurance, encouragement, being with the woman, social chit-chat), instruction/information, and
advocacy. Gagnon and Waghorn's (1996) study found that nurses with less than 7 years experience provided more supportive care than the more experienced nurses. Additionally, supportive care was given more frequently to nulliparous than the parous women.

When supportive care was given, it was primarily in the verbal form (Gagnon & Waghorn, 1996; Klein et al., 1981; McNiven et al., 1992). However, the value of the support in the form of verbal communication offered can be questioned. Danziger (1979) conducted an ethnographic study and focused on the interactions between women in the early stage of labour and staff members which included physicians and nurses. Danziger analyzed interactions between maternity staff and 13 women during childbirth and found that the caregiver attempted to assert control over the social process of labour. She found that the hospital staff had internalized the rules for proper conduct of the childbearing woman and her partner. These rules were communicated directly or indirectly to the patient and there was little, if any, room for negotiation. Consequently, the patients conformed to these rules and rarely disregarded or violated them. Additionally, the staff generally ignored expressions of the woman's experience of childbirth. Only the expression of pain appeared to be acknowledged.

Beaton (1990) corroborates Danziger's (1979) findings. Using the Stiles Taxonomy of Verbal Response Modes instrument to analyze the maternity nurse-patient interaction, Beaton found that her sample of nurses presumed to know what the labouring woman was experiencing and did not regard the woman's viewpoint as relevant when it was expressed. Individualization of care was not apparent. Nurses defined and controlled the childbirth experience with little input from the patient.

Studies concerning the childbearing women's perceptions regarding the role of the intrapartum nurse have yielded results that appear to be dependent on the nature of the sample of childbearing women. Mackey &
Lock (1989) conducted semi-structured interviews antenatally with 61 multigravida women and found 28 percent of these women expected the nurse to leave them alone with their husband. The remaining sample of multigravida women were equally divided into the categories of moderate and high expectations of nurse involvement. In contrast, Bond et al. (1995) conducted semi-structured interviews antenatally and postnatally with 56 primigravida mothers who intended to give up their infants for adoption. The researchers found antenatally that nearly all participants expected the nurse’s continuous presence during labour, and postnatally, the interviewees described the nurse’s continuous presence as helpful. However, the study was unique in that the sample consisted of only relinquishing mothers, that the sole source of support for these mothers was the nurse, and that antenatally, the mothers were aware they would be provided with a high degree of continuity of care.

Childbearing women in Callister’s (1993) phenomenological study described nursing care in terms of the competence of the nurse, the broad range of skills they possessed, and the degree of responsibility they demonstrated. Based on this study, satisfaction with nursing care was universally positive. This study was an exception to all other studies found because negative comments were not reported by the researcher. The data were derived from 26 primiparous women who experienced uncomplicated vaginal births, received epidurals and had “supportive” husbands.

Women’s psychological outcomes of childbirth are related to the level of satisfaction with the nursing care they receive. It has been found that satisfaction with nursing care during labour and delivery is present when women a) have received a sufficient quantity of information during labour and delivery, b) perceive themselves as in control of the childbearing process, c) are allowed to participate in the decision making during childbearing and d) judge the quality of the relationship between the labouring woman and the
nurse to be good (Brown & Lumley, 1994; Davenport-Slack & Boylen, 1974; Green, Coupland & Kitzinger, 1990; Sequin, Therrien, Champagne & Larouche, 1989; Sullivan & Beeman, 1982). Furthermore, it is evident from these studies that support -- the little that was received by patients -- was the most appreciated component of the nursing care that was received.

Not only is the quality of intrapartum care associated with women’s psychological outcomes, it affects length of labour, number of obstetrical complications and interventions, infant morbidity, and the incidence of caesarean sections (Hodnett, 1998; Radin et al., 1993). Hodnett and Osborn (1989) conducted a stratified randomized controlled trial of two groups in Toronto to determine the effects of continuous one-to-one care. The experimental intervention consisted of the presence of a continuous caregiver during labour. They found that there was a significant reduction of episiotomies and analgesia or anaesthesia when labouring women were assigned to the continuous support group.

In addition to the labour and delivery nurses’ evolving technological environment, the nurses have become immersed in a new environmental condition, that is, restructuring. Obstetrical nurses in Ontario nurse in an environment where health care funding has declined. The change in the provincial government in 1995 precipitated decreased funding of acute care hospitals and restructuring initiatives. Acute care hospital budgets had been reduced by 6.3% (Health Services Restructuring Commission, 1997), thereby creating a negative impact on hospital resources, most notably the relevance here being the decrease in staffing levels of obstetrical nurses.

Summary

Nursing care provided to women in labour has been demonstrated to have an impact on women’s birth outcomes. A greater understanding of the intrapartum nurses’ working environment in the context of health care restructuring may illuminate the reasons why certain types of nurses’
behaviour occurs or fails to occur. Descriptions of care during labour and delivery have been elicited from interviews with childbearing women. Additionally, intrapartum nurses' activities have been examined by time or work sampling methods. Analysis of interaction between maternity care provider and patient has delineated patterns of communication. However, little research data have been generated from labour and delivery nurses themselves. The only data obtained from labour and delivery nurses was in response to investigator-conceived questions and these data were indistinguishable from data generated from antepartum nurses, postpartum nurses and obstetrical administrators in a study done over 40 years ago. Since then interventions such as electronic fetal monitoring, continuous epidural anaesthesia and operative deliveries have become commonplace. Current research exclusively derived from labour and delivery nurses' experiences is lacking.

Purpose/Research Question

The purpose of this study was to explore and describe labour and delivery nurses' experiences in the late 1990s. The original research question which was planned to guide this study was “What is it like to be a labour and delivery nurse in an obstetrical unit?” However, with the unexpected event of significant hospital restructuring and staffing cuts evolving during the data collection period, the actual research question became “What is it like to be a labour and delivery nurse in an obstetrical unit during health care restructuring?”

METHOD

Research Design

The method selected for this research project was grounded theory. Grounded theory is discovered from data systematically obtained from social research (Glaser & Strauss, 1967). The theory is developed inductively and is grounded in descriptions of life experiences of the subjects (Artinian, 1988).
Grounded theory makes its greatest contribution in topic areas that are characterized by a scarcity of information (Artinian, 1988; Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Simms, 1981). Because there was a dearth of data on the experiences of labour and delivery nurses, it was premature to generate hypotheses to be tested. Furthermore, it was not clear what concepts concerning intrapartum nurses were appropriate to study. Grounded theory was a suitable method because the data collected from the nurses themselves could be intimately linked to concepts/ hypotheses that could be ultimately developed into a theory designed to illuminate intrapartum nurses' behaviour within a hospital setting where restructuring was taking place.

Grounded theory research provided a way to a) conceptualize intrapartum nurses' behaviour in complex situations, b) understand unresolved problems, and c) understand the impact of new ideologies (Chenitz & Swanson, 1986). These intrapartum nurses were immersed in a complex social situation. They interacted continually with patients and their families, physicians, colleagues and administrative staff in the context of a complex changing organization, that is, a hospital undergoing restructuring. Additionally, in the past two decades intrapartum nurses have had to deal with the impact of a new technical ideology (which values fetal monitoring, drugs, and ultrasound) on their nursing practice (Sandelowski, 1988). Because these nurses were confronted with a technical ideology and worked in complex situations amidst social upheaval, grounded theory made an ideal research methodology to study the problem under investigation.

Gaining Entry to Site

An urban teaching hospital that has approximately 2,500 deliveries per year was chosen because the characteristics of the site implied that there was numerous obstetrical staff interacting with each other, and that it was a complex environment. An unexpected environmental characteristic at the commencement of data collection was the fact that the hospital started
undergoing restructuring involving budget cuts which resulted in intrapartum nurses being laid-off. Additionally, it was announced that the hospital's labour and delivery unit was to be dismantled and assimilated into two other existing sites on an undetermined date in the future.

Upon obtaining approval from the thesis committee and the Office of Research Services at the University of Toronto, copies of the thesis proposal were submitted to the Nursing Research Committee and the Research Ethics Board of the participating hospital. Once permission was obtained from both these bodies, an explanatory letter along with the thesis proposal was submitted to the Director of Nursing for the Surgical Directorate at the participating hospital, the Director of Nursing Education and Research of the participating hospital, and the Labour and Delivery Nursing Unit Administrator.

**Sampling**

Once permission was granted from the foregoing three individuals, a list of the nurses' names who currently work in the labour and delivery area (casual nurses excepted) was obtained from the Labour and Delivery Nursing Unit Administrator and an explanatory memo (Appendix A, p. 118) was prepared for those nurses. Memos were placed in an individually addressed envelope and left at the nursing station. At the bottom of this memo there was a perforated portion, that at the outset, allowed nurses to indicate that they did not wish to be contacted to participate in the study.

One week after the memo had been made available, the investigator conducted 15 minute presentations to each of the four teams of staff intrapartum nurses. The presentation elaborated on the information provided in the memo and gave the nurses opportunity to ask questions regarding the study. The presentation was conducted during a quiet period in the labour and delivery area. At the conclusion of the first presentation, a clearly marked box was placed in the nursing lounge that gave the nurses the opportunity to
place the perforated portion of the memo in the box, thereby indicating that they did not wish any further contact with the researcher. After the four presentations had been conducted and approximately 2 weeks after the memos were made available, the contents of the box were examined by the researcher. Two nurses indicated that they did not want to be contacted by the researcher. The investigator utilized the first guideline for subject selection (Appendix B, p. 119) and selected five intrapartum nurses in the labour and delivery unit and left a letter addressed to those nurses in the labour and delivery unit's mailbox located in the nurses lounge. The letter (Appendix C, p. 120) requested that the nurse telephone the investigator at home in order that a more detailed explanation of the study could be given. After approximately 1 week, if there was no response from the selected intrapartum nurse, a reminder memo (Appendix D, p. 121) was left in her mailbox. When there was still no response, an attempt to contact the nurse at work was made to confirm whether or not she was interested in participating in the study.

Once the nurse indicated that she was interested in participating in the study, a telephone explanation was given (Appendix E, p. 122). At the conclusion of the telephone explanation, the intrapartum nurse was asked whether she would or would not participate. If a favourable response was given by the nurse, she was then asked whether she would like to be interviewed at the hospital while on duty or would she rather be interviewed at home on her own time. If she selected the hospital as the interview site, the subject was asked to give the investigator the dates that she was scheduled to work. Then the investigator called the subject when she was on shift and determined if the unit was busy or not. If the unit was not busy, the investigator came to the hospital as soon as time permitted and further questions pertaining to the study were answered and written consent (Appendix F, p. 124) was obtained. Alternatively, if the nurse elected to have the interview conducted at her home on her own time, time was provided there
to answer questions and obtain written consent. Once the nurse consented to participate, a copy of the consent form and a copy of the telephone explanation were left with the subject.

The investigator utilized convenience sampling to select nurses to be interviewed from the list obtained from the Nursing Unit Administrator of Labour and Delivery. Initially, it was the investigator's intention to interview 5 nurses, determine properties and dimensions of the categories derived from the data collected from these first interviewees, and following this, engage in purposive sampling with other subjects based on the categories and properties established. However, problems in recruiting subjects due to lack of response to the investigator's letter, the negative effect of restructuring on the nurses' attitudes, and a dwindling sample pool due to lay-offs led the investigator to abandon this proposed technique. Consequently, the data collection period was much longer than anticipated and convenience sampling was used throughout the entire research study.

The total number of nurses eligible for subject selection in April, 1996 was 28. Four nurses were selected and interviewed during the period of April, 1996 to October, 1996. In October, 1996 six nurses were laid-off based on their lack of seniority and the subject pool dwindled to 22. A further 4 nurses were selected and interviewed from this reduced sample pool. The first interviews were completed by August, 1997. The first 4 nurses interviewed elected to conduct a second interview with the investigator. The last 4 subjects interviewed declined the opportunity to participate in a second interview and indicated that they had nothing further to say. During the time period of April, 1997 to August, 1998, all of the first interviews were conducted and transcribed. From October 1997 to February 1998, second interviews were conducted with 4 of the 8 subjects. Therefore a sample consisting of 8 intrapartum nurses (more than a third of the 22 nurses remaining after the October, 1996 lay-offs) generated the data for this study.
A total of 15 nurses were contacted by the investigator about participating in the study. Of the 15 nurses contacted, 8 agreed to participate. Only one nurse responded to the letter asking her to contact the investigator regarding potential participation in the study. Two subjects contacted the investigator once they were given a reminder memo. The remaining 5 subjects were contacted by investigator-initiated phone calls before they agreed to participate. All but one nurse agreed to be audiotaped. The nurse who declined to be audiotaped agreed to be interviewed and have field notes taken. The field notes were transcribed in point form during the interview and amplified into a written transcription within 24 hours of the interview.

Description of Sample

Of the 8 nurses in the sample, 5 indicated that they have had children themselves. One of these nurses indicated that she experienced childbirth without the use of epidural anaesthetic, whereas 3 nurses indicated that they did have an epidural anaesthetic during childbirth. The details of one of the nurse's childbirth experience were not known.

Two of the 8 nurses had been midwives in England before engaging in obstetrical nursing; the rest of the nurses had been educated in Canada and did not have a midwifery background. All the nurses had been employed in the labour and delivery unit at the participating hospital for at least 6 years, and, therefore, all the nurses had considerable experience in labour and delivery. The age of the participants ranged from approximately 30 to 55 years of age.

Data Collection

The primary method for data collection was through unstructured interviews (Denzin, 1989). It was planned to have two interviews for each subject within a 6 month period. However, because of an unexpected lack of interest in participating in the study possibly related to the restructuring process, this plan was modified. Instead, the data were collected over a 22 month time span and the second interview became voluntary as opposed to
being expected. The researcher began with a broad question "Please tell me—What it is like for you being a labour and delivery nurse?" (see Appendix G, p. 126). This broad question allowed for free expression of the respondent and thereby avoided researcher bias. Most of the data were obtained by means of neutral probes, and reflecting on what the interviewee had previously said. On occasion, the investigator offered data from other interviews to be commented on by the subject—data both from her own and others' previous interviews.

Prior to the collection of data, bracketing was carried out by writing down the data expected to be received by the investigator during the interview with the nurses (Appendix H, p. 127). Bracketing was used to help avoid the preconceived assumptions of the investigator (who was an intrapartum nurse for 15 years but never in this setting) by attempting to suspend what the investigator previously thought about the experience being studied.

The interviews were audiotaped and a 60 minute tape was utilized. The duration of the interview ranged from 30 minutes (primarily in the second interviews) to 1 hour (the time limit of tape). Some nurses were motivated to talk longer. After the tape was finished, the investigator continued to listen to the subjects who wanted to speak further. The content served to augment the interview data as more background and personal data were revealed by the subject which were recorded later in memos.

The first four subjects had their initial interview prior to the event of lay-offs of six intrapartum nurses in October, 1996. These four subjects each participated in two interviews. Subjects were asked to participate in a second interview to: a) check if the nurse had thought of anything she wished to add to the content of the first interview; b) allow the investigator to clarify and amplify the points in the first interview; and c) allow the subject to comment on the other participants' views. The time between the first and second interviews ranged from 12 to 18 months. The reasons for the significant time
lapse between interviews was due to the lay-offs of nurses, the difficulty of recruiting subjects, requirement of modification of the protocol which included the investigator contacting subjects rather than the subjects contacting the investigator and selecting subjects without the use of a key informant, and having to suspend data collection while permission for these modifications was acquired. One of these four nurses' second interview was completed via telephone, and field notes were compiled immediately after the telephone conversation. The last four subjects who had participated in initial interviews that took place after October, 1996 were also asked to participate in a second interview. However, they indicated that they had nothing more to say and therefore declined the offer to participate in a second interview.

Four of the 8 subjects elected to have their interviews conducted in the hospital in an abandoned office on the labour and delivery unit. Four of the 8 subjects elected to have the interview conducted at their homes on their own time. Every one of the subjects was congenial and forthcoming with their information and the location of the interview did not seem to affect the nature of the data procured.

**Data Analysis**

Each interview was transcribed by the investigator. The page mechanics were as follows: a) wide left margin for personal notes and “in-vivo” codes or categories; and b) right half of page was left blank to record the causal conditions, phenomenon, context, intervening conditions, action/interactional strategies, and consequences surrounding the pieces of data related to each phenomenon identified (Strauss & Corbin, 1990). Since the data analysis was provisional, the coding was done in pencil. Coding was interrupted at any point to write theoretical notes.

Grounded theory methodology necessitates simultaneous data collection, data organization and theory formation. The constant comparative method of qualitative analysis was utilized in each of the four stages of coding: a) open
coding—developing categories or comparing incidents applicable to each
developed category, b) axial coding—integrating categories and their
properties or developing relationships between categories and subcategories,
c) selective coding—delimiting the theory or developing a story line, and d)
writing the final draft of the theory (Glaser & Strauss, 1967).

The investigator used several strategies for open coding recommended
by Strauss (1987) that included: a) looking for in-vivo codes (i.e., verbatim
quotes used by the subjects); b) giving a provisional name to each code; c)
asking questions about words, phrases and sentences in the line by line
analysis; d) moving quickly to name dimensions that are relevant to the
phrases and words; e) comparing the dimension to other cases; f) and paying
attention to the coding paradigm. The coding paradigm based on symbolic
interactionism that was suggested by Strauss and Corbin (1990) was used. The
data were coded according to: a) the conditions of the context of the situation,
b) the interaction and strategies employed by the subjects in the situation, and
c) the consequences of each interaction or strategy. The condition’s context
referred to the particular set of conditions (events, incidents, happenings) or
structural conditions within which the action/strategy takes place (Strauss &
Corbin, 1990). Action/interaction represent the strategies that were devised to
manage, handle, carry out, or respond to specific phenomenon (Strauss &
Corbin, 1990). The outcomes or results of action and interaction were deemed
consequences. In the process of open coding, the data were fractured and
examined minutely line-by-line whereby categories and their inherent
properties and dimensions, that is, conditions, action, interactions and
consequences, were identified. The data were coded as to category and its
dimensions, and compared with previous incidents in the same category. This
comparison was often based on memory.

In addition to coding, memo writing was utilized as a helpful adjunct.

After each interview was completed, four types of memos or notes were
written. These included: observational notes, theoretical notes, methodological notes, and personal memos. Observational notes served to document facts and events witnessed by the researcher through watching and listening on site and contained minimal interpretation. Theoretical notes represented thinking about observational notes and interview material whereby some interpretations of data, conjectures and other private thoughts were described. Methodological notes reflected thought regarding the investigator's research tactics, that is, a critique of research tactics or instruction to the researcher herself about the methodological process. Finally, personal memos were written to describe feelings experienced by the researcher, or the condition of the researcher, and allowed for the analysis of the relationship between researcher and subject. Observational, theoretical, methodological, and personal memos were written within 24 hours of the interview.

Following the process of open coding, the process of axial coding was undertaken. In axial coding the data were put back together in new ways by making connections between a category and its sub-categories. The category (phenomenon) was identified and the sub-categories (context/condition, action/interaction strategies, and consequences) were related to the category. This analytic process was carried out and resulted in which categories were described in terms of their salient properties, dimensions and relationships, thereby giving the categories richness and density.

Next, the task of integrating categories to form grounded theory was undertaken. The relating of categories to formulate a story line (the conceptualization of the study, that is, a descriptive narrative about the central phenomenon of the study) was accomplished through selective coding. Once enough nurses were sampled to provide adequate data to establish categories of a phenomenon, and delineation of the conditions, actions/interactions, and consequences surrounding the phenomenon was accomplished, a
tentative story line or core category was formulated and committed to. At that point, a few sentences describing what was believed by the investigator to be the main story were written down. This concept was deemed to be the core category.

After all of the interviews were completely analyzed, the definitive core category was identified. Once the core category was decided upon, the subsidiary categories around the core category were related to each other by means of the paradigm -conditions/context, actions/strategies, and consequences. The categories were arranged and rearranged according to the paradigmatic relationships in order to adequately fit the story line. A matrix was then developed in which the core category was identified and the overall phase of the process was shown as well as how the subcategories were related to the six major categories.

Credibility of Findings

Several factors such as history or events that occur before data collection, subject maturation, subject sampling bias, subject mortality, and changes in the observer all affect validity. However, validity is most affected by the reactive effects of the researcher in qualitative studies (Chenitz & Swanson, 1986).

The effects of the observer were a particular threat to internal validity in this study. The primary source of data was interviews. Therefore, the truthfulness of labour and delivery nurses' reports of their perceived experience was crucial to the validity of this study. The nurses may have reacted to the presence of the researcher thereby producing an unconscious or conscious distortion of their verbal information. Because the subjects may want to report data that shows them in the best possible light, they may lie, omit data or misrepresent their claims (LeCompte & Goetz, 1982). Additionally, the subjects may have motives unbeknownst to the researcher that influence the content of their data in such a way to further their cause. Throughout the
interviews the investigator dealt with these possible scenarios by employing the tactics of forfeiting the opportunity to challenge the respondents' interview data and of conveying an attitude of acceptance of whatever was said. However, the problems of the intrapartum nurses presenting their data in the best possible light, omitting data, overstating their problems, and misrepresenting their claims may exist thereby effecting the internal validity of the data obtained.

In order to enhance validity, the investigator employed several tactics. The interview was conducted either in their own home or in a private room where confidentiality was assured. Protecting privacy and stressing the confidential nature of the interview hopefully fostered "truthfulness". Throughout the interviews, the investigator tried to convey the message that the informants' views were acceptable and valued. Additionally, after all the data had been analyzed and a matrix was developed, the investigator shared the content of the matrix (Appendix I, p. 128) with six of the eight subjects and encouraged their comments on the validity of the matrix. Two subjects were unavailable for comment.

The subjects were contacted twice by telephone after receiving the proposed matrix. In the first telephone call, the core category "preserving the sparkle", the categories and their respective sub-categories were explained in detail. All of the subjects agreed that the matrix "pretty well covered it all", and not one subject verbalized disagreement in the depiction of the storyline. After meeting with thesis committee members, the basic social process' labelling was changed from "preserving the sparkle" to "preservative managing" as it was believed the latter better captured the essence of the process. A second telephone call was made to the subjects to verify the appropriateness of the core category's nomenclature change. The subjects agreed the change was positive and stated "that sounds very good" or "that is very well put" after being given further details regarding the core category.
The use of self as a research instrument was employed in this study. Validity is enhanced when the use of self develops reflexivity, or an awareness or consciousness on the part of the researcher of her own role in the process (Kahn, 1993). Validity was enhanced when the researcher accounted for the relationship between the investigator and the informant. Personal memos helped me discover and account for that relationship.

In grounded theory external validity is increased if a diverse variety of subjects is present (Chenitz & Swanson, 1986). Because of the limited subject selection pool, especially after the event of significant lay-offs, and the reluctance of many potential subjects to participate in the study, the sample consisted of 8 subjects rather than the original 10 proposed. However, diversity existed among the procured subjects in their childbirth, nursing, and personal backgrounds. And despite these differences, they all concurred with the validity of the matrix developed.

Reliability refers to the accuracy of a measurement instrument. Since the researcher is the instrument, the reliability of the study relies on the researcher’s skill, creativity, time, resources and analytic ability (Chenitz, 1986). To increase reliability, all of the data derived from the 12 interviews were coded independently by the thesis supervisor and the researcher. Discrepancies in coding were discussed and a consensus was reached.

**Ethical Considerations**

**Informed Consent**

The intrapartum nurses selected by the investigator were approached by the investigator only after they had not taken the opportunity to deposit the slip in the box which indicated their wish not to be contacted. After further explanation (Appendix E, p. 122) was given and the subject indicated a willingness to participate, a consent form (Appendix F, p. 124) was presented. During this process, nurses were informed of their right to withdraw from participating in the study at any time. However, it was expected that the nurse
would participate in up to two face-to-face interviews if she signed the consent. The nurses recruited earlier in the study did so; the second half of the sample elected not to—possibly because restructuring was well advanced at their initial interview and by time the opportunity for a second interview arose, they had experienced minimal change in their work environment so that they did not feel the need to report further. The investigator also acknowledged demonstrations of implied consent and withdrawal of consent during the interview sessions. Although it had been expected that the nurse would participate in two face-to-face interviews if she signed the consent, the investigator accepted the latter 4 subjects' wish to forego a second interview and one of the first 4 subjects' wish to have the second interview by telephone.

Confidentiality

Because the nature of the material generated in the interview had the potential to be damaging to retaining their jobs if the information were to be leaked to others, participating intrapartum nurses were given verbal and written assurance of the confidentiality of their responses. The investigator and her thesis supervisor, Dr. J. Chapman, were the only two people that reviewed and had access to the interview transcripts. Individual nurses may be able to recognize their own words in the report; however, it is unlikely that anyone else will be able to identify their words in the quotes used. All interview transcripts and data were assigned a number. Consent forms were kept separately from data during the study. Tapes and transcripts were destroyed at the end of the study; consent forms will be kept in a locked file for the 6 years required by the Office of Research Services.

Limitations of the Study

The nurses may have been cautious in relating information to the researcher, therefore the data may not be complete. Another limitation was that the sampled subjects may represent an abbreviated sample thereby
creating the situation where some phenomena may have not been sampled or missed. Fourteen of the nurses were not sampled. Furthermore, the information generated also may be limited by the nurses' recall of their experiences.

The nurses studied were undergoing restructuring and were encountering change. The event of restructuring appeared to give rise to negative emotions in some nurses which may have coloured and amplified certain findings. Some data may have been amplified because of anger underlying the depiction of their work life.

There is no intention to generalize findings with grounded theory. The sample consists of nurses employed in a modern, urbanized, highly technical obstetrical unit that is in the midst of restructuring and the findings pertain to only this sample.

The data generated from the nurses is limited by the interviewer's skill. The interview was the primary source of data. Consequently, the data may be weak because they are supported by insufficient observation. Further study by means of participant observation may subsequently be necessary to strengthen the theory.

RESULTS
The Basic Social Process

The basic social process or core category (Strauss & Corbin, 1990, p. 116) derived from the data provided by the labour and delivery nurses was “preservative managing.” The core category of “preservative managing” subsumed six major categories: (a) comparing and contrasting satisfaction; (b) living with political and environmental forces; (c) maintaining safety as top priority; (d) being challenged; (e) providing support; and (f) engaging in professional relationships. The core category and its components were interfaced with the process of “spiralling downward.” The following section will describe the core category, the process, the six major categories and the
respective sub-categories, and the interface of the core category's components and process in more detail.

**Core Category - Preservative Managing**

All eight nurses depicted childbearing as a positive process which was sometimes jeopardized with untoward events. Consequently, the intrapartum nurses were challenged to preserve this positive process by managing events surrounding childbirth. Preservative managing was deemed successful (that is a positive process) when the nurse was able to achieve two conditions—a healthy infant and a happy mother. One nurse described her involvement in the experience of childbirth as follows:

"for me being an obstetrical nurse is supporting the natural processes and enhancing it (sic) to help a mom get through labour and have a good experience and to have a good outcome." (Subject 1)

The nurses presumed that the happiness of the mother was primarily dependent on the health status of the baby. These two elements were closely related to the satisfaction of the nurse. All of these subjects indicated that they probably would not find similar job satisfaction outside of obstetrics.

All eight nurses described their work in labour and delivery in terms of keeping childbirth safe from harm. Harm was depicted in various forms and was contingent on the individual nurses’ perception of harm. Although potential harm was most prominently described in terms of physiological/pathological events, these nurses related several other factors such as prolongation of labour, the “difficult” patient, and living with political forces within the hospital as being formidable threats to preserving a positive childbirth experience. The nurses were managing what they perceived as potentially harmful events in order to keep childbirth a positive experience. They were frequently challenged as they lived with unpredictability, nursed complex patients and attempted to maintain quality nursing care under difficult circumstances. The nurses often did not act alone when managing the childbirth process and engaged in professional relationships with others such
as physicians and other nurses to assist them in achieving their goal.

There was wide variation in what the nurse regarded as important to a positive childbirth experience. While all eight nurses regarded the delivery of a healthy baby as essential, some nurses indicated that they believed that full participation of the mother (limited by what the nurse perceived as safe), adequate pain relief, and the positive psychological aspects of childbirth such as control and empowerment were desirable in preserving. However, some nurses' regarded the delivery of a healthy baby as the only feature worth preserving in the childbearing process. For example, one nurse stated: "My only concern is that she have a safe delivery." (Subject 6) This statement is contrasted to another nurse's statement:

"going through natural childbirth I think it's a very empowering and exciting, albeit painful experience, and I feel that it's a growth and development issue for women." (Subject 1)

She then went on to bemoan her perception that childbearing women are losing that type of experience:

"you reflect on how we're (women) willing to let someone take over and to manage our bodies, and not want to take responsibility for that (childbirth)...I'm not satisfied with the way things are." (Subject 1)

This nurse went beyond the basic preserving the safety of the childbirth experience to attempting to preserve the psychological aspects of empowerment and control in the process of childbearing. Because the nurses' definition of a positive childbirth experience ranged from basically surviving the experience with minimal pain, to a self-actualizing event that was growth producing, the perceptions of what was important to preserve differed between nurses. Although the nurses did have their personal philosophies and views of childbirth, all eight nurses acknowledged supporting the childbearing woman in various ways during managing childbirth in order to preserve maternal satisfaction.

The intrapartum nurses oversaw the childbearing process and believed they were primarily responsible for the outcome. Intrapartum nurses were
aware of the effect their behaviour had on the women's childbirth experience. Nurses perceived that they were critical to the outcome of the childbearing experience. One nurse stated:

"you should be proud that you are an RN, and the fact that you are so directly involved as a labour floor nurse in the outcome, you can make a delivery a miserable experience, or you can make it a wonderful experience." (Subject 3)

Another nurse expressed the same theme in the following quote:

"You know, the nurse seems to be the person who makes or breaks your (childbirth) experience here and I'd like to feel I'm the one who makes it not breaks it. And I think hopefully, and usually I'm successful at that, and I'd like to think that maybe it's not my fault if I'm not successful at that." (Subject 4)

Because the nurses believed they had an effect on the childbearing process and were placed in a position that made them responsible for determining the outcome, they engaged in managing the experience.

Their personal biases, experience, biography, and interactions with other professionals tended to impact on the type of management the childbearing woman received. Some nurses had chosen a management style that encouraged the patient's participation and attempted to include the patient's childbirth wishes as fully as the nurses' preceptions of safety would allow. As one nurse stated: "through whatever little control you have, you end up being able to make that (childbirth) experience fairly close to what they (patient) had in mind." (Subject 2) Other nurses had a more controlling style of managing where they attempted to "run the show." One nurse expressed surprise as she stated:

"I think sometimes that it's actually a shock for us when it's pointed out to us that there is a doctor and actually that person does run the show (laughs)....But most of the time it's really (us)..." (Subject 7)

The management of the childbirth experience not only was based on the nurses' management styles and the awareness of the effect they had on the experience, but was also based on what the nurse perceived as worth preserving as negotiated—to a greater or lesser degree—with the patient.
The Process - Spiralling Downward

The effect of the politics of restructuring on the labour and delivery unit was an insidious and continuous process which resulted in the deterioration of the quality of the intrapartum nurses' environment. The word "politics" was used frequently by intrapartum nurses to represent administrators' actions which affected nurses' work life. The nurses anticipated and adapted to changing conditions where their colleagues and resources were adversely affected. Several of these nurses described the consequences of political restructuring as "stressful" and "frustrating." One nurse described the restructuring process she was immersed in as being "on a downward spiral." (Subject 4) As the effects of politics caused a spiralling descent in the quality of the labour and delivery environment, the nurses corresponded with proportionate increases in the level of energy to deal with restructuring forces that threatened to negatively impact on the experience of childbirth. The process of the restructuring downward spiral was generally a seamless, gradual process. However, two incidents did have an effect that episodically intensified the descent, that is, the lay-offs on the labour and delivery unit that occurred in October, 1996, and the hiring of a Nursing Unit Administrator in September, 1997 who was deemed by the nursing staff to lack understanding of obstetrics due to inexperience in the area. There was an increasing number of reports of working with more patients and fewer staff after the lay-offs in October 1996. (Following which the last 4 subjects' total data and the second interview data of the first 4 subjects were collected.) The tone of the first 4 interviews was generally positive. However, after the restructuring initiatives were implemented, that is, the reduction of nursing staff, a more negative tone to the interviews was apparent. The hiring of a new Nursing Unit Administrator was first mentioned in October, 1997 when the first of the four second interviews was conducted. Some nurses interviewed after the new Nursing Unit Administrator was hired spontaneously mentioned
that the new Nursing Unit Administrator lacked obstetrical clinical skills. They perceived the lack of clinical skills as a potential problem because she would be unable to assist the intrapartum nurses when they encountered clinical difficulties. The nurses expected their nursing unit administrator to be clinically competent because their former nursing unit administrator was clinically competent and she assisted them when they needed her help. It appeared to some nurses that one more workplace support had been removed.

The Six Main Theoretical Concepts and Subcategories of Preservative Managing

There were six broad categories of the intrapartum nurses' experience. Through the process of restructuring some categories gained more prominence in delineating and illuminating the intrapartum nurses' work life at certain times whereas other categories or subcategories receded in importance. This prominence is depicted by differentiating single from double line arrows in Table 1, page 29. The six categories and their respective subcategories included (a) comparing and contrasting satisfaction -- comparing satisfaction in terms of previous experience in labour and delivery versus other clinical areas, dampening of satisfaction, (b) living with political forces -- leaving politics at the door, living with fear and insecurity, mitigating/adapting to the deleterious forces of politics, (c) maintaining safety as top priority -- regarding safety as non-negotiable, being vigilant, relying on technology, striving to give safe care to all patients, (d) being challenged -- living with unpredictability, nursing complex patients, making the difficult patient less difficult, being challenged to maintain quality care, (e) providing support -- bringing confidence into the room, advocating for the patient versus the physician, informing and educating the childbearing couple, being there/not being there, being the person the patient needs you to be, providing indirect support, and (f) engaging in professional relationships
Table 1

Preservative managing while spiralling downward: An analytical diagram depicting spiralling downward across the six categories, and the subcategories of the experiences of nurses who care for women in labour and delivery in a time of hospital restructuring.

<table>
<thead>
<tr>
<th>Phase -&gt; Categories ↓</th>
<th>---</th>
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<th>---</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparing and Contrasting Satisfaction</td>
<td>Comparing with Other Areas</td>
<td>Comparing L&amp;D with former times</td>
<td>Dampening Satisfaction</td>
</tr>
<tr>
<td>Living with Political Forces</td>
<td>Leaving Politics at the Door</td>
<td>Living with Fear and Insecurity</td>
<td>Mitigating/Adapting to the Deleterious Forces of Politics</td>
</tr>
<tr>
<td>Maintaining Safety as Top Priority</td>
<td>Regarding Safety as Non-negotiable</td>
<td>Being Vigilant</td>
<td>Relying on Technology</td>
</tr>
<tr>
<td>Being Challenged</td>
<td>Living with Unpredictability</td>
<td>Nursing Complex Patients</td>
<td>Making the Difficult Patient Less Difficult</td>
</tr>
<tr>
<td>Providing Support</td>
<td>Bringing Confidence into the Room</td>
<td>Advocating for the Patient</td>
<td>Informating and Educating the Childbearing Couple</td>
</tr>
<tr>
<td>Engaging in Professional Relationships</td>
<td>Working as a Team</td>
<td>Supporting Colleagues - Not Supporting Colleagues</td>
<td>Not Being Supported by Others</td>
</tr>
</tbody>
</table>
working as a team, supporting/not supporting colleagues, not being supported by others, and enjoying autonomy.

The following section will describe in detail the categories and their respective subcategories which will illustrate and further elucidate the theoretical process of Preservative Managing While Spiralling Downward.

Comparing and Contrasting Satisfaction

These labour and delivery nurses universally characterized their job as satisfying. However, as time wore on the event of restructuring insiduously affected the quality of nursing care that the intrapartum nurses were able to provide, and subsequently, their satisfaction with their job declined. To capture the essence of the phenomenon comparing and contrasting satisfaction, there were two subcategories delineated, that is, comparing satisfaction in terms of previous experience in labour and delivery versus other clinical areas and the dampening of satisfaction.

Comparing Satisfaction in Terms of Previous Experience in Labour and Delivery versus Other Clinical Areas

In the earlier interviews the nurses made positive comments about their jobs in labour and delivery and often described their experiences in glowing terms. To add depth and meaning to their descriptions they often compared and contrasted the labour and delivery area to other clinical areas in the hospital. The comparison always yielded a positive result for obstetrics. One nurse stated: “It's a good job. It's one of the better jobs in nursing I think. I've worked many other places in the hospital and I prefer to stay in labour and delivery as my option.” (Subject 3) Another nurse corroborated these comments by stating: “I was really bored and frustrated with training. And then all of a sudden we did obstetrics and I just fell in love with it.” (Subject 1) It would be reasonable to conclude that these intrapartum nurses had a natural liking and affinity for the labour and delivery area and did not want to work anywhere else.
However, when some subjects were interviewed for a second time or their interview occurred after the reduction of staff, their characterization and comparison took on a different tone. The nurses compared and contrasted their experience as a labour and delivery nurse to the period of time when the labour and delivery area was more well staffed, resources were not as scarce, and administrative support was present. One nurse illustrated the changing work environment by stating:

"Sometimes I leave patients alone for up to an hour because I have to attend to another patient who needs immediate attention. I feel bad about this and don't like it. But that's the kind of situation the higher ups have created by reducing the staffing." (Subject 5)

One subject compared her present work experience and satisfaction to the previous time period before health care restructuring by saying:

"It used to be very satisfying for me.... But whether I'd want to do it (going into obstetrical nursing) again, I don't know, I'd have to think seriously about that." (Subject 6)

Another subject stated:

"The care is still there but I think we as people -- we looked forward to going to work, now I don't think that excitement is there anymore, I think we think about what's going to happen tomorrow." (Subject 3)

Generally, the nurses implicitly and explicitly mourned the loss of a higher level of satisfaction and enjoyment of being a labour and delivery nurse. However, despite the lowering of their satisfaction they tried to salvage the experience and blamed the negative effects of politics of inflicting dissatisfaction on their work, and not the actual work. This conclusion is given credence by Subject 3 who stated in her second interview: "It's still labour and delivery and the actual work is good, but the politics are awful."

Another nurse stated in her second interview: “I still enjoy coming to work. The patients. I don't enjoy coming to work with the politics.” (Subject 4)

Although some subjects stated that their experience as intrapartum nurses was deteriorating significantly, not all subjects indicated a decrement in satisfaction with their work. A subject who was interviewed in the later
part of the research study stated: "In general, I think working in labour and delivery is the best place you could ever work. And I say that because it's very satisfying." (Subject 7) Another nurse who was interviewed late in the research period stated:

“Well, I really like it. I love my job and, uhhh, I really enjoy it. You get to work with the patient, it's uhhh, I don't know how to explain it, I don't know, it's a really happy environment.” (Subject 8)

Both of these nurses mentioned the problematic effects of occasional inadequate staffing levels and how that variable slightly affected their experience. However, generally, their satisfaction with their role as a labour and delivery nurse remained relatively unscathed. It seemed that they minimized the impact of the political forces by attempting not to dwell on them, and preserved their role in the couple's birth experience.

**Dampening of Satisfaction**

Despite the variation in the degree of satisfaction and how it was compared and contrasted, the data revealed a dampening of satisfaction during the restructuring. This subcategory is closely related to comparing and contrasting satisfaction in the later period of restructuring where the comparisons were made between the perceived previous good times in the labour and delivery area and the present environment the nurses worked in. Basically, the dampening of satisfaction is the result of comparing and contrasting satisfaction as restructuring progressed. One nurse alluded to the dampening of satisfaction due to looking after several patients and not feeling satisfied with the care she gave by stating:

“When we get busy sometimes I just leave the monitor on because I can't be in two places at one time. You have to split yourself and I don't feel like I'm giving good care to any of my patients. I don't feel good about it but that's the way it is.” (Subject 5)

While several nurses described looking after several patients and feeling a sense of dampened satisfaction with the care they provided, other nurses described the dampening of satisfaction in other areas of their work life.
One nurse described:

"The Christmas party is coming up and there's no one going for lots of reasons. We used to do Christmas skits. The nurses used to get together with the residents, and we don't do that any more. Because again, it's a time management thing. If you don't have to be at work you don't feel like hanging around for an hour and a half after work to do something silly, especially if you've gone without coffee or dinner. It's sad. It's interesting to see how it's changed from 10 years ago when I started." (Subject 3)

Several events contributed to the dampening of satisfaction in the intrapartum nurses' work life. However, this dampening of satisfaction was primarily present outside the patient's room. One nurse actually mentioned putting a "damper" on things. She stated:

"But lately I'm not so sure I'm allowed to do that (taking care of patients). You see, and if you're not allowed to do what is right to do, it sort of puts a damper on things." (Subject 6)

She went on to say:

"And I was so pleased (being thanked by a grateful patient). I suppose whatever problems there was in my life, I left it out there when I walked in here (patient's room). So I think that has a lot to do with attitude..... There's a lot of tension and stress around you." (Subject 6)

Once the nurse was inside the patient's room her job satisfaction was not dampened in most cases, especially when she was not busy splitting herself among several patients.

Living with Political Forces

The intrapartum nurses were immersed in a political environment that they frequently characterized as progressively volatile and inhospitable. One nurse in her second interview described the general situation:

"My actual patient stuff, that is still challenging and I still enjoy coming to work. The patients. I don't enjoy coming to work with the politics. And I work part time so I miss a lot of it." (Subject 4)

As time elapsed over the 22 month interview period, so did the effect of politics on their everyday work life. For example, one nurse stated:

"Political, everything is happening. So it affects us, so I can't answer you about things three years ago, I have to answer you what is happening right now.....when I come out (of the patient's room), the environmental stresses are there. People are unhappy, there's a lot of
tension, you know, it's not that satisfying, there's a lot of things that are causing this.” (Subject 6)

The politics of the hospital threatened to undermine their ability to preserve the positiveness of the labour and delivery experience. The politics of the hospital included reducing the number of nursing staff in labour and delivery in an attempt to save money. One nurse stated: “Right now we have 6 nurses on days during weekdays (they formerly had 8 nurses), and weekends and nights we have only 4 nurses scheduled.” (Subject 5) Also, hiring casual nurses (who were previously employed as full-time) in order to save money on benefits and give the hospital flexibility in staffing created an acrimonious environment as this nurse related:

“It has gotten bad in the last little while because there has been certain nurses laid off and they're coming back on a casual basis or a part time basis, and they're very angry, they're angry, and I know of one girl in particular who seems to be angry all the time.” (Subject 8)

Another measure designed to cut down on sick time expense was implementing a policy which appeared to alienate nurses as this nurse in her second interview explained:

“The (hospital) has imposed a really punitive sick time policy which they have gone to great lengths to deny as punitive, but every year the amount of days you're allowed to take is reduced.” (Subject 1)

Furthermore, hiring a Nurse Manager who was perceived to support administration but not the nurses augmented the intrapartum nurses' unhappiness with politics as this nurse described:

“She's an administrator. She isn't meant to work labour and delivery, but...so if we approach her with a problem, which she has no idea..... uhmm...she's not there to back us up. She works 9 to 5 and her pager goes off at 5 o'clock. We cannot reach her. She is very much a “yes” person, to administration, but not to the nurses....” (Subject 3)

The nurses, like it or not, were living with political forces. As ascertained from the above descriptions, politics were deemed a negative force that had to be reckoned with. The nurses were angry because they had to work with less staff and no longer had a nursing unit administrator that could
help them when they encountered clinical difficulties. It appeared that the nursing unit administrator was taking the brunt of the nurses’ frustrations regarding the negative changes that restructuring imposed on their working environment. Several of the nurses thought of the potential impact that the political forces had on the experience of childbirth. Consequently, leaving politics at the door became an important strategy utilized by the nurses when caring for women in labour and delivery. The political forces produced an environment where the nurses were living with fear and insecurity associated with the future of their livelihood. In order to make their existence with the political forces more tolerable the nurses engaged in mitigating/adapting to the deleterious forces of politics.

**Leaving Politics at the Door**

Several nurses strived to preserve a positive childbirth experience by leaving politics at the door of the patient’s room. They were determined that the politics were not going to preclude the patient from having a positive childbirth experience, and controlled their emotions and actions in order to achieve that goal. One nurse stated:

“but when you walk into that room, with that patient, you leave it outside the door, you see...You can go in to--through the door--with a smile on your face and when you go out through the door, you’re back in the environment where the stress is. But once you walk in to--through the door--you see the patient, you have them see what you want them to see.” (Subject 6)

Although nurses attempted to separate politics from the childbirth experience, sometimes they found it beyond their control, like this nurse who stated:

“just the whole fact of being under those sorts of stresses (heavy workload)..... so it can be very hard to be “up” and happy and be as forthcoming with the information that we need to be giving and to be spontaneous with the TLC we need to be giving, and that adds to the stress because you know in your heart that you’re not doing as good a job as you should be.” (Subject 7)

The subcategory leaving politics at the door had a close relationship to the core category, preservative managing.
Living with Fear and Insecurity

A prominent subcategory in the restructured intrapartum nurses' work life was living with fear and insecurity, especially in the later stages of restructuring. In the early stages of the interviewing period, there was infrequent mention of fear and insecurity associated with the political process. However, as things spiralled downward and several of their nursing colleagues were laid-off and the prospect of having their labour and delivery unit assimilated into another hospital loomed on the horizon, there was great concern as nurses feared that they might lose their job in the process as illustrated by this nurse who stated:

“IT’s very frustrating for all of us here because we don’t know if were going to the low risk (Hospital A) or to the high risk (Hospital B). That’s what we’re told and we don’t know anything other than what we’re told. We don’t know if we have to apply for a job at (Hospital B). If you don’t have your degree, are you going to get a job at (Hospital B)” (Subject 4)

Another nurse corroborates this sense of fear and insecurity and stated:

“I think people are afraid to lose the comfort of their environment, they’re afraid to go to a new unit and lose seniority…. ”

She went on to state:

“People are fighting for their jobs, people are fighting for their livelihood. People know that there is going to be jobs lost in the future, and you know they are looking elsewhere.” (Subject 3)

Stress was an outcome when living with fear and insecurity as this one subject noticed: “the stress being, I guess, the fact that we are no longer a unit, we are a unit waiting to be dismantled.” (Subject 3) Another nurse thought that living with fear and insecurity left them disempowered as she stated:

“Things are on a downward spiral. Like you don’t know where the bottom is. They just don’t give us any information. Information empowers and we don’t have the knowledge. They have us.” (Subject 4)

The above statements indicate that the nurses were experiencing the fear of impending job loss. Fighting for their jobs and competition amongst nurses became an issue. Although the nurses in this labour and delivery unit were
laid-off based on seniority, those with seniority were worried that the new hospital that their labour and delivery unit was designated to be transferred to would not accept nurses without a degree. Additionally, they were uncertain that their seniority would remain intact once they joined the new hospital.

**Mitigating/Adapting to the Deleterious Forces of Politics**

Various strategies were employed when mitigating/adapting to the deleterious forces of politics. These strategies were dependent on the nurses’ perception of the problems associated with the politics, the individual nurses’ personality characteristics, and the specific events associated with the restructuring process. Earlier in the restructuring process there was infrequent mention of strategies designed to deal with the deleterious forces of politics. Two examples of avoiding political forces were found in the early data. One example was related to the researcher by one nurse (Subject 3), who confided prior to the start of the interview that she worked only nights to avoid the politics. Another nurse in her first interview used the strategy of not thinking about politics as she stated: “I’m very happy with what I do. Sometimes the politics that surround it, you know (cringes), but if you don’t think about that, you know.” (Subject 4) Other than these two examples, little data were obtained on this subcategory early in the interview period. These strategies were augmented by utilizing some supports in the workplace that were available to the nurses in the earlier period. At that time they could rely on a manager who had clinical skills. One nurse compared her present manager to the previous manager as follows:

“you can’t expect her (present nurse manager) to be there all the time, not that our old manager was, but she was always around if you needed her where this one couldn’t be relied on in an emergency.” (Subject 3)

In addition to the presence of a manager who could assist them in the clinical area, another workplace support that was present in the earlier interview period was the opportunity to take breaks to get refreshed. One nurse (Subject 4) talked about “nice breaks” and appreciated that opportunity to get
refreshed. However, later in the interviewing period there was frequent mention of going without breaks and the toll it took on the nurses. For example one nurse stated:

"As a rule, we have to work 13 hours in the caseroom without a break. You get overtime almost every shift." (Subject 3)

Another nurse stated:

"We aren't going to help the situation any if we lock ourselves in the room with the patient and grumble...or show unpleasant faces. Okay, so none of us got breaks." (Subject 6)

As the health care restructuring process proceeded, the erosion of workplace supports such as a supportive nurse manager and meal breaks added to the effects of other political events which necessitated the use of other strategies to mitigate and adapt to the deleterious forces of politics. These strategies were described in increasing frequency by several nurses. Individual nurses had different strategies in adapting/mitigating the political forces. For example, one nurse dealt with the politics and the heavier workload by keeping herself in good physical shape as she explained:

"In order to cope with the stress I try to remain physically fit by walking on my days off. You have to ward off stress and fatigue because it can affect your performance at work." (Subject 5)

The strategy of working only nights, which was mentioned briefly by another nurse in the earlier period of restructuring, was employed. One subject stated:

"I work a lot of nights and I miss a lot of the politics that goes on during the day." (Subject 4) Another nurse tried to accept difficult relationships with colleagues that were exacerbated by political forces while she tried to feel good about herself. She stated:

"the point is that you really have to feel true to yourself and feel good about what you're doing and it all goes back to professionalism, that is, doing your best job and if you have an altercation with somebody, you have an altercation but it really doesn't matter." (Subject 7)

As mentioned previously, while a healthy baby and happy mother was their foremost goal, the goal of working in a congenial and supportive
environment was also important to the satisfaction of the nurses.

Some nurses engaged in mourning the loss of valuable colleagues, and simultaneously disparaged the remaining “weaker” colleagues while bemoaning the injustice of it all. One nurse lamented:

“I no longer take charge because you are the one who's going to be ultimately responsible. We've lost seven very strong nurses due to cutbacks and kept nurses who I don't necessarily feel are strong. They are just there to do a job and I'm going to be ultimately responsible for them and any mistakes.” (Subject 3)

The nurses interviewed became overburdened and tried to cope the best they could. “Doing your best” and “doing more with less” were common themes in the data. Preservative management of the childbirth experience that included the goal of healthy baby and a happy mom was replaced by preserving safety in childbirth which may or may not include satisfaction with the childbirth experience. Not being able to attain maternal satisfaction with the birth experience was dissatisfying to the nurses as they were not able to preserve what they deemed as worthwhile preserving. As one nurse put it:

“We are expected to do more and more. The bottom line is babies come one of two ways, as we both know, that is, vaginal or section. You either end up having a good relationship with your patient or not so good. They either feel fulfilled or they don't feel it, they feel that they've been rushed.” (Subject 4)

There was a lowering of the intrapartum nurses' expectations of the quality of the care they were able to provide. And this situation generated dissatisfaction within the nurses. The nurses were willing in most cases to sacrifice their own well-being by forfeiting breaks, carrying unreasonable patient loads in order to preserve what they perceived as the positive aspects of childbirth, and thus avoiding their own dissatisfaction with the quality of care they provided. However, there were limits of tolerance that each individual nurse possessed and some suggested that their limit of tolerance for the inhospitable political environment they worked in had been exceeded. Once this condition had been reached, new strategies emerged.
Several nurses resigned themselves to the situation at hand. One nurse stated "You know I'm at the stage where I've been nursing for so many years, and I'm too young to retire and too old to afford to quit." (Subject 6) Another nurse wistfully stated:

"We're running from room to room looking at fetal hearts and checking epidural blocks, and that bothers me. Cause it feels like I'm not giving good care. I go home and say I haven't given good care and I haven't been the type of nurse and support that I would have liked to be." (Subject 8)

Some nurses decided to try and do something about the political forces as described by this nurse:

"But I'm also not the sort to sit there and be not satisfied. I'm always trying to come up with a new game plan. And there's always a way around it." (Subject 1)

However, some nurses had moved beyond that. This is illustrated by one nurse who said:

"I think a year ago we all loved obstetrics, and we were willing to fight for it. I don't think that's the case anymore." (Subject 3)

She goes on to say:

"If you're not happy doing what you are, and working twice as hard and not being counted as somebody who has relevant information, then you need to decide on where you want to be, and for a lot of people it's not wanting to work obstetrics anymore." (Subject 3)

Another nurse was planning to escape the negative political forces by moving to another hospital which she perceived had more stability. She stated:

"I've applied to for a casual job at another hospital so that I can have my foot in the door (of a hospital), one that looks like it's never going to close." (Subject 4)

Some nurses were willing to fight for their job, while others were planning to flee from this situation and its inherent negative job conditions.

**Maintaining Safety as Top Priority**

Nurses were unanimous in maintaining safety as top priority. As one nurse asserted "The priorities are a safe mom and a safe baby." (Subject 3) If
the safety of the childbearing experience was perceived to be compromised in any fashion, there were attempts to correct the situation in order to make the conditions safe. They were not willing to tolerate the childbearing environment if they found that they could not carry out nursing care in a safe manner. The maintenance of safety was a constant variable throughout the research study and its importance did not waiver. However, as the political environment became progressively more inhospitable, safety was perceived to be affected more often. Some nurses stated that their nursing licences, and therefore their livelihood, were jeopardized unnecessarily by the administration's mandate to reduce labour costs. It appeared that nurses considered that they were the sacrificial lamb in cutting costs, and would bear the brunt of unsafe care. For example one nurse said:

"We have felt very unsafe and I don’t want to see my license go. You come up against these situations, and then when it comes down to brass tacks so (they say) ‘Why didn’t you say something?’ But I wasn’t able to come out of the room with so and so, so I wasn’t able to be there. That part is frustrating too." (Subject 4)

Another nurse reflected on the safety implications of reduced staffing and stated:

"But that’s the kind of situation that we had in the late 80s where we had reduced staffing, the numbers were similar to what we had now. But there was a catastrophe that resulted in a coroner’s case and the coroner’s recommendation was to increase staffing to prevent a similar situation from occurring." (Subject 5)

The nurses asserted that they had to protect the patient and, simultaneously, protect their registration by maintaining safety as the top priority. If they were unable to maintain safety, the childbirth experience was jeopardized, thereby making it a potentially devastating experience for everyone. The nurses managed the childbirth experience in order to maintain safety. When safety was not maintained, the nurses perceived that the childbirth experience in terms of a healthy baby and happy mother would be compromised and therefore not preserved.
Regarding Safety as Non-negotiable

As the nurses cared for patients in labour and delivery, they were regarding safety as non-negotiable. Nurses qualified the care they gave patients on several occasions with “as long as it doesn’t hurt the baby” (Subject 7) or “as long as it’s safe” (Subject 3) or “my only concern is that she have a safe delivery” (Subject 8). When describing the care the childbearing woman would receive, the nurses often would go along with the patient’s wishes for childbirth unless the nurses deemed that the patient’s wishes violated the unspoken safety rule. If the nurse thought that the patient was compromising safety by expressing wishes that were in conflict with safety, the nurse would attempt to override the patient’s desires and inform her that her wishes were not reasonable. In order to illustrate this point one nurse stated:

“My big goal is to get a happy, healthy baby and mom. Whichever way it happens. To me it doesn’t matter so as long as they’re both healthy and that’s not always their goal. They want to have a vaginal delivery at all costs, then I have to get back to where that’s coming from. You have to get them to talk about why that’s so important.” (Subject 4)

Sometimes the nurse would get frustrated with the patient and would recruit others to ensure that the patient understood the risks she was taking. For example, one nurse stated:

“Sometimes you just want to yell at the patient. You don’t, but you sometimes want to say “Your baby’s going to be sick, your baby’s going to die!” you know. But you don’t say that, you present that to them. And you may be presenting in a loud voice, and they don’t want to look at your face. And you have to get other people involved, whether it would be the pediatrician, or the staff person, you know, you’re not the only person.” (Subject 3)

It was the goal of the labour and delivery nurse to have a “wonderfully safe, healthy delivery” (Subject 3), and no less. It was understood and taken for granted that the patient wanted this result also.

Being Vigilant

In order to help promote safety in childbirth, the nurses employed the strategy of being vigilant. The practice of being vigilant was closely
associated with rapid and accurate assessment of the health status of the patient and her baby on an almost continuous basis. One nurse described it as “doing a head to toe” (Subject 2) whereas another nurse “cases the situation” (Subject 1) and these actions are performed almost automatically throughout the childbearing process. Also, the nurses mentioned “being on your toes” (Subject 4) or “being sharp” (Subject 5) as behaviours helpful, if not essential, to ensuring safety. Sometimes the situation necessitated intense vigilance as this nurse describes:

“like having a fetal heart tracing that's not really reassuring but not non-reassuring enough to go in and do a caesarean section but you know it's something you have to sit on and watch like a hawk and ultimately as a nurse, you are responsible.” (Subject 7)

When the practice of being vigilant and its partner, alerting the doctor, was not carried out it had negative consequences for safety as this nurse explains:

“we alert the doctors as to when we're concerned about the fetal heart tracing, when the labour is not progressing, or like in our maternal high risk when we think there is a problem arising. Uhm, you know, and if you're not--and we see it happen on our floor--where some of the nurses are not as strong as they should be, that things can go really bad if you don't alert the doctors.” (Subject 2)

**Relying on Technology**

The nurses relied not only on their own powers of observation, they found themselves relying on technology to ensure the safety of childbirth. The fetal monitor was a large component of their technological care that assisted in their pursuit of a safe delivery. If there was any doubt to the health status of the fetus, fetal monitoring was implemented. The fetal monitor was utilized to reveal ominous fetal heart tracing patterns, to assure the nurse that the baby was okay, or to alert the nurse if a poor fetal heart tracing happened to develop. One nurse explained her use of the monitor as follows:

“there has been times where somebody who has come in and has had a perfectly healthy pregnancy and nothing unusual going on and you put them on the monitor and you’re not getting a reassuring tracing at all....I still think that there is something, it’s not that invasive to the patient, and it (the admission strip) is still a relatively valuable assessment tool.” (Subject 2)
Another nurse explained fetal heart monitoring and its use by stating:

"Usually when a patient comes in we put the patient on the monitor and we get an initial strip. We see what the status of the baby is. You see? But then sometimes that patient could be left on the monitor for over an hour. And I don't think that's necessary. But then when the patient is on syntocinon--sometimes we give them the syntocinon drip to help with the contractions--then we monitor the baby because then we have to see how the fetus is coping with the contractions." (Subject 6)

Central monitoring, especially in the later stages of restructuring, was used as a safety net or a "babysitting" device during extremely busy periods in labour and delivery in which the nurse did not have the time to actually be with the patient. As one nurse remarked:

"Thank God for central monitoring some days, because you either don't get back to the room to read that monitor and if the monitor is on, you either provide a nurse in the room or you better get central monitoring because it is not acceptable to put a monitor on and not go back for 2 or 3 hours." (Subject 1)

Another nurse said:

"One of the main things I do is monitoring the mom and baby. We have central monitoring at the desk and we can watch that. If we are very busy, you can look at the monitor on the patients that don't require one-to-one care and chart on them later." (Subject 5)

In addition to being viewed as a safety net for detecting problematic fetal heart tracings when the nurses were unable to attend the patient, central monitoring was used as a convenience for the nurses because they reported it gave them some freedom to be outside the room. One nurse said that some patients did not require or desire the nurse's constant attendance at the bedside and central monitoring facilitated this. She stated:

"Well I mean if a person is comfortable with an epidural and they're resting and the fetal heart is stable and we have central monitoring on our floor, so it means we don't have to be in there watching the fetal heart monitor all the time because there is one at the desk." (Subject 2)

The nurses indicated their belief that with the implementation of central monitoring the bare minimum requirement of ensuring safety of the baby and mom was met. Central monitoring provided them the sense of safety at times when the nurses were outside the patients' rooms.
Striving to Give Safe Care to All Patients

The nurses were very concerned with safety and engaged in striving to give safe care to all patients. As mentioned previously safety took precedence over every aspect of providing nursing care. Patient wishes for their childbirth experience were subordinated to the safety component of care. In the early part of the study ensuring the safety of childbirth was taken for granted and the nurses did not have to make any serious effort to achieve this condition. However, as things spiralled downward, the nurses had to manage several patients thereby creating the condition whereby striving to give safe care to all patients was something that required serious effort.

Not only were there concerns over the individual patient's wishes and their compatibility with safety, the degree of threat to safety amongst individual patients vied for the intrapartum nurses' attention. Nurses provided nursing care to their individual patient assignments; however, if a critically ill patient or patient who experienced severe fetal distress was present in the labour and delivery area, their own patient was abandoned if it was considered safe to do so. The nurses would provide nursing care necessary to the survival of any patient and baby whose safety was seriously endangered. One nurse stated:

"Most of them are low risk but if we get a low risk that goes sour, and then all of a sudden you've got everybody looking after this patient and then What's going on with the other patients?--and patients are still coming in." (Subject 4)

Several nurses would participate in the care of one critically ill patient thereby precipitating nurses' neglect of other women in labour. There seemed to be the implicit rule that all patients had to be considered safely cared for before other care was performed. There was a collective responsibility evidenced amongst these nurses to ensure safety for all patients. An example of this phenomenon is demonstrated by the statement made by one of the nurses. She said:

"But we get the most bizarre cases, and some of them are so ill, two or
three nurses could potentially be tied up for hours just because there's so much happening. So personnel are flying everywhere. Sometimes there's doctors from five or six services and an ICU nurse and one or two or three labour and delivery nurses and everybody is totally bogged down with the care of that one patient, which then has issues for the other 9 or 10 or 12 patients who are on the floor.” (Subject 1)

**Being Challenged**

Almost all of the nurses spoke of being challenged. Although the nurses were presented with challenges on a regular basis, these challenges differed in context, character, when they appeared, and frequency. Whether the situation was regarded as challenging depended on the perception of the nurse involved and this perception was influenced by the nurses' abilities, experience, and character. The challenges presented to the nurses were divided into four subcategories, that is, living with unpredictability, nursing complex patients, making the difficult patient less difficult, and being challenged to maintain quality nursing care.

**Living with Unpredictability**

In the labour and delivery unit there were several scenarios described in which the nurse had to respond to the rapidly changing situation. Whether it be the presence of fetal distress, the arrival of a critically ill patient, or a patient who suddenly was progressing quickly, the nurses were challenged to rapidly and accurately assess the situation, and respond appropriately to these events. The nature of these situations described by nurses suggested that the nurses were living with unpredictability when they work in the labour and delivery area. As one nurse remarked:

"You try to work with the patient, you try to find out what their needs and wants are at any given time. And that can change very rapidly in labour and delivery.” (Subject 3)

Another nurse equated the labour and delivery unit with an emergency department as she stated:

"We're kind of like the emergency department only that instead of one patient coming in we have two. The mom and the baby we have to look after too. So you're always kind of on your toes.” (Subject 4)
The unpredictableness of the patient's condition coupled with the unpredictableness of what was coming through the door made the nurse's work exciting and challenging. The nurses had to adapt their nursing care rapidly and proficiently in order to cope with the challenges that unfolded in a sometimes unexpected manner. Some nurses said they felt secure in their abilities to handle whatever situation arose, and no longer regarded the unpredictable environment as a challenge to them, like this nurse who stated:

"I think that if I was put in any situation in labour and delivery I could deal with it. I may not deal with it right, but I could deal with it. And that's taken a lot of years." (Subject 3)

**Nursing Complex Patients**

Other challenges were described in the data provided by the nurses, that is, nursing complex patients with little or no knowledge pertaining to the patient's medical condition. There were reports that patients with complicated medical conditions were becoming more prevalent in this labour and delivery area. One nurse stated: "so what used to be really abnormal is becoming more of the norm." (Subject 4) There was the assumption that medical technology was advancing to keep ever increasing numbers of women with serious medical conditions alive longer, thereby enabling them to become pregnant. Therefore the nurses believed that they were getting more and more critically ill patients which challenged them to a significant degree.

The nurses were challenged because they could not keep up with the medical knowledge required in giving quality care. And, furthermore, they did not use their medical knowledge obtained in the past often enough to feel competent in managing the care of these patients. Consequently, the nurses related that the care required to nurse obstetrical patients with acute medical conditions sometimes exceeded their repertoire of skills and abilities because of their lack of experience, and for lack of knowledge concerning these types of patients. For example one nurse revealed:

"they're transferred in -- the situation is frequently very acute and very little information provided. Frequently a diagnosis is not there so
you’re dealing with the ongoing situation, frequently in labour plus the complications added as they occur and trying to diagnose at the same moment.” (Subject 1)

Another nurse stated:

“We deal with a lot of high risk mums, cardiac mums, transplant mums....we have a special pregnancy unit. Challenging in the fact that you’re not just working with the normal labour and delivery and you’re trying to pool your resources and put your brains together-- remembering something that you’ve not remembered for 3 or 4 or 5 or 6 years....” (Subject 3)

One nurse described the potential risks with these patients as she stated:

“Because they have such a high morbidity rate, and morbidity and mortality rate. Like we had somebody with a massive dissecting aneurysm that went down from their subclavian down to their iliac arch. More often than not, like, uhhh, like the one we have coming up has portal hypertension and ascites, esophageal varices who most likely won’t make it to term because she’ll....” (Subject 2)

Although these patients were unusual in the labour and delivery unit, they left a marked impression on the nurses, and were thought of as the most challenging patients when implementing physical nursing care.

Making the Difficult Patient Less Difficult

In addition to physical care, psychological care was cited as sometimes challenging, and the difficult patient was a common theme in the data. When the difficult patient was mentioned the nurse proceeded in making the difficult patient less difficult. The difficult patient was usually described as a patient who had definite ideas of how her birth experience should unfold. The difficult patient was described in this manner:

“Oh, you get a few of those! The difficult patient, you know, “I don’t want an epidural”, and “I want my husband, my mother, my sister, my brother, in fact the whole human race who belong to my family in the room with me.” And “I don’t want to stay in the bed, I like to walk around.” (Then the nurse says to herself) “Well madam you can’t walk around. But you see, you have to stay in bed because you have to monitor the baby, the heart rate isn’t that great.” You won’t say to the patient that the heart rate isn’t that great but you need to keep her there.” (Subject 6)

She goes on to make the difficult patient less difficult and illustrates this by saying:
“Sometimes you have to take a very firm stance. You have to. And what I noticed is if you have a patient that's very difficult, which we do get, you can get one in five patients that is very difficult. And if you are sort of firm and not rude, they come around.” (Subject 6)

Another nurse depicted the difficult patient differently and, also, attempted to make the difficult patient less difficult. She stated:

“people come to the hospital with sometimes with very specific expectations on what they want to happen and they also have specific biases about what they feel is going to happen and how that's going to infringe on their personal rights. So I think it's pretty challenging to get past that and into trying to convey the message that in fact that we want to see a healthy baby and that we really do want to try and work through things in a way that will be good for both the patient and the staff of the hospital, because it's not going to work for anybody if we're at loggerheads.” (Subject 7)

Two nurses (Subject 6 and Subject 3) mentioned that some nurses cannot tolerate the difficult patient and have to switch patient assignments “because the day is going to be ruined completely.” (Subject 6) The nurses attempted to manage the childbirth experience in a way which they perceived as necessary in order to preserve a healthy baby. It appeared that the nurses were protecting the baby from their own mothers whom the nurses perceived to lack adequate knowledge and experience in childbirth. However, some of their management styles were often steeped in control and the presence of a healthy baby appeared to be the only thing that they wanted to preserve. In these instances, these nurses appeared not to be very interested in preserving maternal satisfaction.

Being Challenged to Maintain Quality Care

As the restructuring process progressed, the nurses were stressed with having to care for multiple patients and, consequently, being challenged to give good quality nursing care became their most pressing challenge. All of the nurses spoke of their difficulty in giving quality nursing care to women in labour and delivery when they had 3 or 4 patients. Because of this workplace condition, safety was what they strived for, specifically making sure everyone was safe. Quality nursing care was an unrealistic goal when
the nurses were overburdened with patients. Dissatisfaction with their nursing care resulted. They came to dislike their jobs because they described themselves as doing poor jobs of which they could not feel proud. As one nurse stated:

"I think it can be challenging because of workload, there can be times where you can be looking after 3 or 4 patients and that makes it challenging to give excellent care to everybody. Sometimes you can only do your best." (Subject 7)

She went on to say:

"and that adds to the stress because you know in your heart that you're not doing as good a job as you should be." (Subject 7)

Another nurse related the same type of scenario as she stated:

"And then it's not like that and it's busy, and we're running from room to room looking at fetal hearts and checking epidural blocks, and that bothers me. Cause it feels like I'm not giving good care." (Subject 8)

In the earlier stages of the process of restructuring there were references to being overburdened with patients when it was busy. However, the reports of this situation were considered infrequent in the early stage when compared to reports in the later stages of the process of restructuring. The nurses' preoccupation with maintaining the quality of nursing care to the patients became an overriding issue.

The conditions that affected the quality of care were numerous. The understaffing of the labour and delivery unit was the primary condition that affected the quality of nursing care, however, other conditions challenged the nurses' ability to maintain quality nursing care. Those conditions related to the nurses being taken away from the patient's bedside and included documentation, computer work, secretarial duties, stocking, portering, equipment issues, and other duties that were part of their job but did not involve direct patient care. None of the nurses stated that they liked these activities and frequently subordinated these activities to patient care. Because these activities vied with patient care for the nurses' time and attention, they detracted from the quality of nursing care the patient received.
Providing Support

Providing support is the most substantive theoretical concepts in this research study and is comprised of seven subcategories, that is, bringing confidence into the room, advocating for the patient and/or the physician, informing and educating the childbearing couple, being there/not being there, being the person the patient needs you to be, and providing indirect support. The type and amount of support that would be provided to the childbearing couple was decided after negotiation among the patient, the physician, and the nurse. The nurse assessed the situation, communicated with the couple, and they worked through the process of childbirth together. The nurse offered support that was contingent on the needs expressed by the patient, the needs that the nurse deemed were appropriate to the situation, and, sometimes, the needs of the physician. The type and amount of support provided was fluid, dynamic, and everchanging. Frequently, several types of support were demonstrated simultaneously, especially in the later stages of restructuring. For example, a nurse may be putting a patient on the fetal heart monitor (enabling the nurse to give reassurance to the mother that the baby is safe), educating the patient on what is entailed in fetal monitoring, developing a rapport, and developing the patient's confidence in the caregiver as a person who is knowledgable in childbirth all at the same time.

One nurse demonstrates this event as she stated:

"We have to check to see on the monitors, the changing and turning, our time has to be utilized well. It has to be--our teaching has to be done at the same time. You can't take the time to sit down with them for 30 minutes and discuss X, Y, or Z, now you're discussing X, Y, or Z with them while you're putting them on the monitor." (Subject 3)

Another nurse illustrated the multifaceted aspects of support by stating:

"You can't have several different people doing different activities like someone reading the monitor strip, someone taking blood, someone giving the patient a bedbath, someone acting as the chaplain to console the patient, and other roles that are assumed by the nurse. Many times these types of needs are immediate and can't wait. The nurses are at the bedside and can provide for most needs in an immediate fashion. Nurses have multi roles and can be flexible and timely in the care she (sic)
provides.” (Subject 5)

**Bringing Confidence into the Room**

Bringing confidence into the room was a subcategory that incorporated two dimensions. First, there was the nurse’s confidence derived from the experience and knowledge in childbirth that she brought with her into her patient’s room and supported the patient with. Then there was the confidence the nurse was able to instill in her patient that enhanced her patient’s capabilities in childbearing.

The first-time childbearing woman and her partner usually have little experience in childbearing and are unfamiliar with the process. However, they usually believe that there is pain involved, and sometimes things can go awry. Therefore, they rely on the nurse to guide them through with her confidence which allows the patient to feel secure in that they have a knowledgable person by their bedside to guide them through childbirth safely while incorporating most of the patient’s wishes in the process. One nurse illustrated this premise by stating:

“And I think it’s a certain confidence we can bring into the room and that can settle everybody down and I think probably patients see that and pick up on that relatively quickly and benefit from that.” (Subject 7)

Another nurse stated:

“we all know the nurse who (her patient) has fetal distress and there are others (nurses) that when you walk into the room the mom calms down and the baby calms down.” (Subject 1)

It appeared that the nurses’ confidence and familiarity with childbearing provided a source of support that generated a sort of peace of mind in the patient which, subsequently, was appreciated by the patient. The patient and her partner often were not familiar with childbearing which, in most cases, made them apprehensive. Therefore, they came to rely on the nurses’ confidence, comprised of judgment and expertise, to help quell their psychological and physical discomfort.
The confidence displayed by the nurse was viewed by her as not only giving her patient a sense of security, it also served as a basis to enable the nurse to impart confidence to the patient. The process of instilling confidence may take the form of verbal encouragement, praise, optimism, and acceptance during labour. While not all of the nurses practiced these confidence building forms of support all of the time, many did. For example, one nurse stated:

“I strongly believe in the powers, passage, and passenger, and the psychological process so if you get those four things working together and get the patient to believe in it, you'll have a good outcome.” (Subject 1)

In a context related to the decision making process involved in having an epidural anaesthetic, a nurse stated:

“If she thinks she can't do it, right, like going back to the epidural, if she thinks that she can't handle it, I can't do this any longer, I need something for pain. I'll say “Do you want an epidural?” And she says “I don't know.” I'll help her through it......If she thinks she's keen, I'm going to help her and emotionally support her in those decisions that she made prior going into labour.” (Subject 8)

In this instance, the nurse is trying support the patient by fortifying the patient's wavering confidence in her abilities to make it through childbirth without an epidural anaesthetic. The nurses who practiced in this manner attempted to preserve maternal satisfaction in childbearing.

**Advocating for the Patient**

The intrapartum nurse on occasion engaged in advocating for the patient. The context in which the nurse found herself either made it relatively easy or extremely difficult for her to advocate for the patient. There were forces such as perception of safety, personality of the nurse, the patient, and the physician that had a profound impact on whether the nurse advocated for the patient. In several instances there was a conflict within the nurse when she was faced with advocating for the patient. As mentioned previously, the nurse would not advocate for the patient if she thought that in advocating she would compromise safety. Safety reigned supreme in the scheme of things. However, when putting the issue of violating safety aside,
the nurse strived to advocate for the patient in that she tried to incorporate the patient's wishes for the childbirth experience. Generally, nurses supported the idea of patient advocacy and said: "You try to work with the patient, you try to find out what their needs and wants are at any given time." (Subject 3), or

"Sometimes when they have a birth plan or something like that (so) you know what they want during the labour, and not often but sometimes they do, and usually it is within our limits to give because it's usually things we do anyways." (Subject 6)

All of the nurses alluded to incorporating, some if not all, of the patient's wishes into the provision of nursing care. Nurses would advocate for the patient if the patient's desires were considered not to jeopardize safety, and not to conflict with the physician's wishes.

What appeared to affect the nurses greatly was the situation where the physician's wishes conflicted with the patient's wishes. Some nurses were able to handle the physicians like this nurse who stated:

"Some of our physicians are very hands on, following the OMA guidelines of examining the patient every 2 hours and augmenting their labour...uhmm...and (I'm) trying to be the mediator...between...like if the patient comes in and the patient says I want to do this on my own, naturally and I don't want anyone to break my water and you (the nurse) are the person who says to the doctor "you know, why don't you go look at somebody else?" That person is doing fine. Instead of making everyone active management, some people don't require active management, some people can do very well on their own." (Subject 3)

Another nurse had more difficulty in handling this situation as she stated:

"Personalities can be a problem but hopefully the next time you work with them (doctors) it won't be so bad...... That is so frustrating and, so... there's another word I want to use but I can't think of it now. Because you're caught in the middle, because you know that the patient is going one way and you know the doctor is going the other way, you know it's just not getting the way everybody would like it to go. So I do find it......(pained look) and I know I'm supposed to be a patient's advocate and I feel helpless sometimes because I can't do that." (Subject 4)

However, one nurse in a sympathetic tone deferred to the physician stating:

"And I'm perfectly happy with the fact that they (doctors) have the ultimate responsibility in managing their patient 'cause it is their patient. And something I do have a problem with is with the patient
advocacy thing. I am an advocate but that doesn’t mean that their doctor isn’t. And some nurses feel that it’s their role to be an advocate but it’s against the doctors and it’s not. Because they (doctors) feel very hurt about that and they really do feel hurt about that. They hate it when the nurses say “Well I’m the patient’s advocate” because it’s a very snobby thing to say. Because why would they be delivering babies if they didn’t like their job and if they didn’t want to be there.” (Subject 1)

Although nurses universally expressed advocating for the patient by incorporating the patient’s wants and needs into their provision of nursing care to varying degrees, it appeared that the nurses differed in their belief about patient advocacy when it came to conflicts between their own, the physician’s and the patient’s desires.

**Informing and Educating the Childbearing Couple**

Numerous accounts of informing and educating the childbearing couple pervaded the data. All of the nurses spoke of keeping the patient informed or advising them of what to expect, how to breathe and relax, interpreting what the doctor just told them, and correcting misinformation they received prenataally. An example of correcting misinformation is demonstrated in this quote:

“In terms of the epidural if somebody doesn’t want one because of misconceptions and not necessarily because they’re committed to going without an epidural, like the fear of the needle or think they’re going to be paralyzed or anything like that, then you have to inform the patient and make sure they are making that decision not on mistruths but because that’s really what they want to do.” (Subject 2)

Alerting and informing the patient to her options was another common occurrence. One nurse stated: “I think you need to be informing patients of their rights and their options at all times during their stay.” (Subject 3) The process of informing and educating also appeared when the nurse was trying to give the patient’s partner support in his supporting abilities. For example, one nurse determined she needed to support the woman’s partner by giving him information. She said:

“So the woman expects their support but they (husbands) feel totally out of their depth because from prenatal classes you’re never going to
develop the level of expertise that the woman needs. So I really try to show the husband different things that they can do and I have them be the relaxation control person.” (Subject 1)

The nurse in this instance is supporting the woman by supporting the husband through education.

**Being There/Not Being There**

The nurses stated they did not have to be present in the patient’s room constantly. In fact there were phrases such as “being a third wheel” present in the data that indicated the nurse’s presence was inappropriate in some contexts. Additionally, several other situations were described that made the nurse’s presence undesirable, not required, she preferred to be elsewhere, or she was simply unavailable. Therefore the subcategory being there/not being there evolved. Sometimes being there was determined by the implicit wishes of the patient or the condition of the patient which necessitated the nurse being present. To illustrate this one nurse said:

“although I might not be in the room all the time that if there comes a point where they would want me to leave to let me know because I don’t know if I will always be able to assess that properly because there could be somebody who I think is coping well and doesn’t really need me and yet inside they feel like they do want me. So I usually make it pretty clear that they have a part in the deciding in how much care they want as well.” (Subject 2)

Additionally, there was the suggestion that the presence of the nurse was personality directed, as in the case of “clicking with patients.” One nurse stated:

“It depends on how you click with the patients too, there’s some that you just...you know...you spend 10 or 12 hours in there even though you don’t need to.” (Subject 2)

Two other nurses (Subject 3 and Subject 4) mentioned “clicking with patients” in their interview. Additionally, the presence of the nurse depended on the presence and competency of the support person the woman had with her. If the support person was non-existent or deemed to be unable or unwilling to provide adequate support, the nurse would try to stay with the patient.

In the earlier part of the interviewing period, “being there” depended
on several factors such as patient's physical status, personality, whether she was accompanied by a competent support person, and to a lesser degree, the busyness of the labour and delivery unit. However, as the number of nurses staffed per shift on the unit diminished, being there with the patient became dependent on the busyness of the labour and delivery unit to a much larger degree.

**Being the Person the Patient Needs You to be**

Providing support was comprised to a large degree of being the person the patient needs you to be. Nurses described the nature of their care as consisting of multiple roles that are everchanging and dependent on whatever the patient needs. Their needs were based on communication from the patient and what the nurse believed the patient needed. The nurse attempted to confirm with the patient as to what was required. One nurse stated "you need to be looking for feedback, that your cues that you're picking up are correct as to what the patient is requiring at the time." (Subject 3) She goes on to describe the variety of activities she undertakes to convey the sense of support:

"but you know, you have to be the comedian, break the ice, be the mediator, be the mediator between the 14 year old girl who's having the baby and wants to keep it and her mother's in there saying "I can't believe she's done this to me." .... So you have to play the parent sometimes. You need to be a grief counsellor, you need to be able to tell them that their baby's not perfect. You have to be there when the physician does tell them and you explain, and , you need to be the person that the patient needs you to be depending on the circumstances. You know, they might just need you to be there just to hold their hand and not say a word and that's okay too. You need to intervene when intervention is necessary, and this is one thing in the medical profession that isn't abnormal. Patients need to know that it's normal and this is okay, and you (the patient) can cry and you can scream and can do whatever you want. Nobody's going to judge you." (Subject 3)

The above passage depicts the multiple support strategies that the nurse employed depending on the context.

Every nurse described her care in terms of "working together" with the patient and supporting her in a manner that was deemed appropriate. Nurses
were sensitive to individual needs of certain patients. For example, they avoided touching patients who they sensed did not invite touch, arranged for patients to receive epidural analgesia in very early labour even though they thought that it was wrong, gave backrubs, breathed with them if the patient was hoping to go without an epidural analgesia, adapting to their (teenagers) developmental level so that they could relate to them, and other behaviours that conveyed support and acceptance. The nurses did not implement care they considered violated the patient’s preferences unless they believed there was a safety issue at stake. They acquired information regarding their patient’s preferences in mostly nonverbal ways and adapted their care accordingly. They did not believe everybody needed or wanted continuous coaching with breathing, touching, backrubbing, educating, and the nurse’s presence. Sometimes the nurses believed it to be supportive not performing these measures. They became what the patient needed or what they perceived the patient needed them to be in most instances.

As restructuring progressed, the tolerance for patient’s individual situations were not dealt with as sensitively. For example, some nurses described care in the labour and delivery unit as giving “assembly line care” because they were too busy to attend to individual needs. The bottom line then dictated how they performed care.

Providing Indirect Support

The nurses engaged in performing many tasks such as urinary catheterization, assisting in epidural administration, implementing oxytocin therapy, scrubbing or circulating in caesarean sections and other tasks that may be considered as technical in nature. They were deemed as necessary either to support the physical processes of childbirth or support the patient’s needs as in pain relief through medication. The nurses performed or assisted in these measures to support the patient indirectly. Basically, they acknowledged that these measures were necessary to the overall well-being of
the mother, and were necessary to help deliver a healthy baby. For example, one nurse stated:

“Well, if they want something for pain, I try to give them all the different alternatives, not just our drugs that we can give them.”

She goes on to say:

“There must be some processes I don’t really think about...like I don’t write down my goals...like obviously I don’t let the patient get a full bladder...I don’t think about I have to put a catheter in, I just put the catheter in and drain the bladder.” (Subject 4)

The nurse described physical types of indirect support that she performed almost subconsciously. In addition to indirect care being performed subconsciously, indirect care was provided by nurses in primarily an autonomous and satisfying manner as one nurse stated:

“Just little things—it’s nice to not to have to be constantly on the phone (to the doctor),—like “can she have something for her heartburn?”, “can she have a foley catheter?”, can she have an intravenous?, the baby’s heart rate is 40.” I mean things just need to be done, and I think it’s satisfying to have the respect that those things need to be done and you just go ahead and do them because we know that we’d be unsafe not to do them.” (Subject 7)

Indirect support to the patient was, in most cases, necessary to women in labour in order to achieve a healthy baby and a satisfying childbirth experience.

Engaging in Professional Relationships

The nurses interacted with a variety of personnel throughout the course of their working life in the labour and delivery unit. The personnel included physicians from diverse areas such as obstetrics, anaesthesia, family practice, paediatrics, and intensive care, and they encountered and interacted with them on a regular basis. Some of these physicians were known to the nurses on a level that was deemed as personal and familiar, thereby exceeding the bounds of what was required on a professional basis. Nursing colleagues were another group of personnel that the nurses interacted with constantly, and with whom they developed, in many cases, personal friendships.
Therefore, engaging in professional relationships was a prominent and meaningful theme in delineating the worklife of nurses in labour and delivery. The subcategories of engaging in professional relationships derived from the data were: working as a team, supporting/not supporting colleagues, being supported by others, and enjoying autonomy.

**Working as a Team**

Working as a team was mentioned by several nurses in describing their relationship with other professionals in the pursuit of the goal of having a healthy baby and happy mother. Also, the nurses described instances where they worked as a team with other nurses, and how well these nurses worked together as a team determined whether the time spent during their shift in labour and delivery was an enjoyable or an unhappy experience. Hence, “making or breaking the shift” (the experience of satisfaction or dissatisfaction during their shift in labour and delivery) was dependent on their team mates and their personality characteristics or moods. Working as a team incorporated all the staff in labour and delivery. However, the two main groups of staff that were primarily functioning as team members were physicians and nurses. The physicians worked with the nurses as a team to enable the childbearing woman to have a healthy baby and satisfying experience whereas, in addition to enabling the childbearing woman to have a good experience, the nurses’ nursing colleagues worked as a team in order for the nurses themselves to have a positive personal experience at work. First the subcategory working as a team will be described in the context of the physician and nurse.

Several nurses described their work in terms of working with the physician in aiding the woman to give birth. Although nurses agreed that the physician had ultimate responsibility in the outcome of childbearing, the nurses frequently viewed the physicians as colleagues implicitly indicating the relationship was based on egalitarian principles. Most nurses sensed that
they had received respect and trust from physicians and, consequently, felt valued because of this phenomenon. One nurse said:

"I mean we work as a team and there's no this hierarchy, "I'm the doctor and you're the nurse". I mean it is there, but we all work as a team and uhm... And like (physician's first name) said "How are her contractions, are they moderate or strong, are they every 2 minutes?" And at that point when I came on she was on syntocinon, so I knew what he was getting at "What are her contractions like so to bump up the pit". But, no, the contractions are fine, and he didn't sit and palpate for 3 minutes to see if I was right." (Subject 8)

Another nurse said:

"I just find it satisfying in just the respect (from the doctor) that you have a brain and you do know what's going on. And really it is an implicit understanding that the doctor couldn't do it without you and the patient couldn't do it without you being there." (Subject 7)

Although all nurses did not sense the same degree of equality with physicians, all nurses reported that their opinion was respected in most instances and they could approach the physician if they had something to contribute to the experience. For example one nurse said:

"Some nurses forget they're nurses. You see? They forget they're nurses in the sense they start telling the doctors their job. You see? And after all you're not here to tell them his job, after all he should know his job. We are here to work as a team. Now, if you think he is doing something that he should not be doing, okay, you could discuss that with him." (Subject 6)

There was an understanding between the physician and nurse that they worked as a team, and this sense of teamwork persisted throughout the health care restructuring.

The nurses worked side-by-side with nurses themselves and frequently engaged in teamwork. Sometimes they would help each other with a delivery, or in an emergency they would work together to help bring an optimal resolution to a dire situation. Whatever the reason, nurses worked together as a team that inspired congeniality in most instances. Early in the restructuring process a nurse stated:

"The team of nurses that you work with can make or break how the night goes. And for the most part I seem to luck through with working with team orientated nurses. Uhm...... sometimes I work with people
who just do their own thing and expect you to help them but they can’t seem to help you.” (Subject 4)

However, as competent nurses were laid-off and less competent, or disgruntled nurses remained or were added, teamwork diminished. Most nurses described the situation as this nurse did.

“We’re all working hard so why complain...If we are here to sort of help each other...Sometimes we get a bunch of nurses who are helpful and lots of times on this floor you get a bunch who are not helpful. And you get that a lot.” (Subject 6)

**Supporting/Not Supporting Colleagues**

Nurses engaged in either supporting or not supporting their colleagues. Some nurses thought that nurses did not support each other to a large extent and attributed it to a “woman thing”. However, as in the context of teamwork, nurses' support of each other diminished as the restructuring process advanced. For example, one nurse was supportive of her colleagues who did not possess the same expertise as she did in the earlier days of restructuring as she said:

“And I think as a nurse you need to realize that with other nurses who are dealing with their first neonatal death, or dealing with all the paperwork that goes with the neonatal death, and I don’t think you need to take over but you need to be in the background and be supportive when required. And you need to know when to step in as a friend or as a colleague.” (Subject 3)

In the later stages of restructuring this same nurse stated:

“we’re coping but we’ve been less cohesive. We are a high risk unit, the same people end up with cardiac patients, the sick patients, and the genetic patients, and we are all R.N.’s, we should be all able to deal with the any kind of patient that walks through the door. But in reality that doesn’t happen. It’s very frustrating.” (Subject 3)

Another nurse had experienced the same phenomenon but instead of eventually disparaging the clinically weaker nurses as her colleague did, she initially states that she feels honoured by their requests for assistance and then as restructuring progresses, she sympathizes with them. She stated in the earlier interview:

“They (nurses) do approach me quite frequently and I feel very
honoured by that. To me that, that's a special moment, to think that they would be able to come to me in the first place and to be able to use what I use and to have respect for the knowledge that I have.” (Subject 1)

Later on in the restructuring process she notes that some physicians are openly hostile towards those nurses (who don't take complex patients) and she stated:

“So they're (the nurses who don't take complex patients) forced to work (due to circumstances). They aren't well enough and that level of acuity is just too much for them. And it's not their fault. They're not bad nurses.” (Subject 1)

There were several descriptions of nurses who were perceived to not take their fair share of the workload in the labour and delivery unit. They were universally described in negative terms and their behaviour was not supported. Those descriptions of unequal workload distribution were vaguely alluded to in the earlier phases of restructuring; however as things spiralled downward, the fairness of workload distribution became a prominent theme when referring to their colleagues. The subcategory of supporting or not supporting colleagues was closely aligned with teamwork because the success of teamwork is determined largely by the support or non-support of nursing colleagues.

Nurses who “lock themselves in a room” with the patient were seen in a negative way, because they were regarded as not being available to help other nurses and avoiding work. This action was construed as not supporting their nursing colleagues. For example one nurse stated:

"sometimes they will lock themselves in their own room with a patient regardless of what stage of labour their patient is in. This patient could be one of those patients which has just started syntocinon. Like you just have to turn up the pit and listen to the baby, there is no need for you to stay in the room with her. But you'll find some of the nurses will stay there. You have to go and say “Look, your patient is stable, could you please come out and give us a hand because we have more patients and you know the situation”, and they don't take too kindly to that.” (Subject 6)

Another nurse corroborated the presence of this phenomenon by stating:

“But there are some nurses on our floor that they get holed up in a
room with one patient and they don't even manage that patient properly. They leave a patient all day not even progressing and it's like so you've sat on her for 10 hours, so why wasn't she on pit 8 hours ago. Or why wasn't she home 8 hours ago. But they're happy to stay in that room and with that patient who's not causing them any problems.” (Subject 2)

It is not known whether this action of “locking themselves in a room” was intended to genuinely support the patient or to avoid work as the subjects in this study claimed. Several nurses were overburdened with the nursing care of multiple patients while some of their colleagues defended their action by asserting they already had one patient. This phenomenon is illustrated by one nurse who stated:

“we do have some people (nurses) who lounge around and take a patient every 2 weeks and that's that. I mean God forbid that they do anything above and beyond like if they have patient who's 101 (patient who is in false labour/early labour). So one of them will take her. Another lady comes along who's active and she'll go “Oh, I have a patient in 101.” Well she's not doing anything, and she can take her (the active patient) as well. But if she's got a patient, she'll throw her hands in the air and not do anything. And that makes it tough.” (Subject 8)

While most nurses were angry with the inequity of the workload, some nurses accepted it, like this one who stated:

“Not everybody works at the same speed and not everybody has the same drive to get as much done as they possibly can and that's the way they are and it's better just to accept that and go through the day and be happy with what you personally have done rather than thinking about what somebody hasn't done.” (Subject 7)

It was generally believed by intrapartum nurses that the nurse made herself unavailable when staying in the room with her patient and therefore was unable to support her colleagues, especially during busy periods in the labour and delivery unit. That could be the reason why the nurses described the problem more frequently in the later days of restructuring.

**Not Being Supported by Others**

Support of the nurses themselves was appreciated by the nurses. They described instances where they did not receive enough support from administration, especially in the later part of restructuring. The nurses
initially had the support and sympathy of their nursing manager and worked under the increasingly heavy burden of patient care without substantial amounts of complaint. However, as the workload increased and a new nursing manager was hired, the nurses believed there was a withdrawal of support. Therefore, not being supported by others became a sub-category. One nurse depicted this problem by stating:

"With the lay-offs we're working a lot harder, therefore it's not unusual to have 3 or 4 labouring patients......There's also the problem of tracking your nursing hours. We're using the GRASP system. It's a very complicated, ineffective system that takes up a lot of your time--and mostly just trying to get into the system because there's a lot of system failures in it. And it just means that there are more and more tasks that you're expected to do." (Subject 1)

This passage reflects the fact that administrative support in the form of financial support had been withdrawn and consequently the nurses were required to shoulder the burden created from the lack of administrative support by caring for more patients and performing more tasks. Some nurses described the new nursing manager as totally budget conscious and not clinically competent, thereby giving the impression that she was unable to support the nurses in any meaningful way. For example one nurse stated:

"But she (Nursing Unit Administrator) doesn't know labour and delivery--she is very well educated but she doesn't know nursing per se, like the hands on, the clinical. And it's very frustrating when you have someone in charge of everything and (who) doesn't know that you're to tell patients that they are to come in for a non stress test when (they phone in and say) she doesn't feel the baby move.....So that's very frustrating, and that goes for all the politics." (Subject 4)

**Enjoying Autonomy**

The nurses established trust and respect from their colleagues and the physicians through interaction while working together. A consequence of the evolution of acquiring trust and respect was the process of enjoying autonomy. All nurses spoke of some type of autonomy, and "running the show" was a common phrase. One nurse demonstrated this theme by stating:

"We do have a great deal of power. More than in any other floor....it's a very acute amount of time you're there with that patient, and you run the show. You can make, you know good out of a bad situation."
The nurses possessed and valued autonomy and it had a large effect on their satisfaction with their job, as shown by this nurse who said:

"as a labour and delivery room nurse you have a lot more autonomy than in other areas of the hospital. It's a feeling of satisfaction that you can make decisions and you can act on those decisions and that we actually have a lot of say in what happens to the patient." (Subject 7)

Several nurses expressed the fact that they operated independently while the physician was elsewhere and they were respected and valued to the degree that they were allowed to operate in this fashion. They usually did not require direction from the physician as in other areas in the hospital, they were expert caregivers, and proud of it. Some nurses mentioned that there were nurses who were not as clinically strong as themselves and these nurses had to endure censure and hostility from the physicians. However, most nurses were expected to maintain a level of care for childbearing women which was predicated on trust and respect that allowed them to care in an autonomous manner.

Preservative Managing While Spiralling Downward -- Interface of Core Category's Components and Process

The process in this study did not consist of separate steps or phases that could be abruptly demarcated. Strauss and Corbin (1990) state that "Some phenomenon do not lend themselves to conceptualization as orderly progressive steps and phases, yet process is very much a part of them." (p.156) The perceived deterioration of intrapartum nurses' environment could not be conceptualized in orderly progressive phases; however, there was a pervasive negative atmosphere generated by downsizing and the withdrawal of workplace supports in the labour and delivery unit that continued to impose a progressively negative effect on the intrapartum nurses' working environment. The process in this study was depicted in terms of "spiralling downwards" in the health care environment. The nurses' aim was to manage
the experience of childbirth in order to keep it positive for both the childbearing woman and themselves in an unstable environment that they perceived as spiralling downwards.

There appeared to be subtle changes in the nurses' behaviour as hospital resources and personal support evaporated. Nurses made constant adjustments in their behaviour to cope with the situation at hand. Actions/interactions were highly variable and context dependent, and stability in the midst of change was the goal of the intrapartum nurses. Each of the following six major categories had an impact on whether the nurses were/were not able to achieve their goals of a healthy baby and happy mother as the nurses engaged in preservative managing.

Comparing and Contrasting Satisfaction

More often in the initial interviews, the nurses described their working environment in positive terms, such as "I love it," "it's very satisfying," or "it can be really fantastic." The nurses described their satisfaction with intrapartum nursing by comparing and contrasting their work environment to other clinical areas in the hospital. One nurse (Subject 1) said, "If it wasn't for the fact that I could be an obstetrical nurse I wouldn't be a nurse at all." And her statement was corroborated at a later time by another nurse (Subject 7) who said "I think working in labour and delivery is the best place you could ever work." However, as the nurses' environment descended down the spiral as evidenced in later data, their satisfaction with their working environment was more often described with reference to the previous enjoyment of the labour and delivery unit as they compared it to the present state of affairs. One nurse stated:

"The morale is terrible at this time.....if you'd ask me this question three years ago my answers would be completely different." (Subject 6)

Living with Political Forces

The political and environmental forces became more prominent in the nurses' everyday life as time went on. These forces were universally
described by nurses as having a negative impact on their environment. For example one nurse stated: “We’ve had times like—how can it get any worse? But things are on a downward spiral.” (Subject 4), and another nurse who stated “the morale has decreased significantly.” (Subject 3) Initially, the political and environmental forces were a minor irritation with most nurses, however, those forces mushroomed so as to impact the nurses’ work life to a profound degree as the interview period progressed, especially after the layoffs that occurred in October, 1996.

To deal with the undesirable effects of politics, various strategies were employed. As the restructuring effects on the nurses' environment began to appear, some of the nurses ignored the politics, worked only nights, and expressed the hope that someone would help alleviate the effect of the negative forces of the politics. However, as the last interviews were completed, an additional strategy appeared, that is, contemplating escape from their inhospitable working environment. The escape strategies included a) thinking about moving to another clinical area “I don’t necessarily want to be working cardiology or emergency or ICU, but I also have to realize that there is potential there.” (Subject 3), b) getting involved in another profession, or c) moving to another hospital. As the hospital administration was implementing their measures to decrease costs of the work force, intrapartum nurses were increasing their repertoire of strategies to adapt to their progressively impoverished working environment, which toward the end of this interview period included leaving the profession, “I have other avenues that I’m looking at, that don’t include nursing.” (Subject 3)

Maintaining Safety as Top Priority

The restructuring of the hospital also had an effect on the nurses' perceived ability to provide safe care. The prerequisite working condition in order for the nurses to express some satisfaction was that the environment be conducive to providing safe care to the patients. Once the environmental
condition was such as to prevent the nurses from providing safe care, the nurses found their job dissatisfying. As things spiralled downward, more and more expressions of providing unsafe care were found in the intrapartum nurses’ data. One nurse stated, “we as nurses, have felt very unsafe, you know, a few times, and semi unsafe a lot of times.” (Subject 4) They believed that if they were unable to maintain safety, a disaster would follow. The nurses in later interviews expressed the opinion that the hospital administration had sacrificed safety, and were overly concerned with the bottom line—“it doesn’t take long for a manager to become totally budget conscious.” (Subject 1) The nurses depicted administration as primarily concerned with the financial aspects of providing care whereas the nurses were concerned with safety within financial constraints.

**Being Challenged**

As the hospital’s restructuring process progressed the nature and the degree of challenges encountered by the intrapartum nurses increased correspondingly. The initial interviews produced data that included challenges such as assuming and mastering multiple roles quickly and effectively, nursing complex patients, and coping with unusual situations competently. In the initial data, there were some references regarding having to bear a heavy patient load on occasion. However, as things descended down the spiral, data from interviews became more laden with descriptions of instances where the challenges of their work were primarily due to trying to care for multiple patients simultaneously. “With the lay-offs we're working a lot harder, therefore it’s not unusual to have 3 or 4 labouring patients.” (Subject 1) Because the accustomed patient assignment was either one or two patients per nurse, these nurses reported that did not have the resources to perform nursing care in a satisfying, timely, and effective manner. As one subject stated, “We’re finding it hard to cope, with having 3 or 4 patients—one of which might be pushing, the other might be needing an epidural and
another might be on pit." (Subject 4) Another nurse remarked, "I only find it challenging when it's busy, because I can't give the care I want to give." (Subject 8) The challenge of providing minimally safe and satisfying care without adequate resources and support became increasingly apparent as the interview period progressed.

Providing Support

Providing support to the women in labour and delivery throughout the restructuring process was significant to the nurses. They supported in an unsupportive environment. Subject 1 stated:

"the budget is just too small for the department, and the acuity of care, so everything has to run around the budget issue. And that has a really significant impact on nursing care."

Another nurse stated: "We don't have the manpower to care." (Subject 4)

Subsequently, nurses employed various strategies that mitigated the impact of the forces that threatened to undermine the nurses' ability to support the patient. As things spiralled downward, not only was the provision of nursing support discussed, but in addition, strategies to protect their environment and to make it amenable to be able to provide support were devised and carried out. Strategies were employed such as leaving the problems at the door (of patient's room). One nurse remarked, "I suppose whatever problems there was (sic) in my life, I left it out there when I walked in here (patient's room)." (Subject 6). Another nurse stated, "I think that people (public) have become accustomed to a certain level of care, and the talk outside (the patient's room) is negative but the smile is still on the face, the motivation is still there when you walk in." (Subject 3)

Engaging in Professional Relationships

The data derived from early interviews with intrapartum nurses revealed, with few exceptions, a congenial, collegial, and supportive relationship between themselves and other health professionals. However, as time went on, these relationships became strained because of the lay-offs and
the decreased number of nurses per shift. One nurse stated, “People are angry because certain colleagues have left and certain ones have stayed.” (Subject 3) She went on to state, “we're coping but we've been less cohesive.” The tolerance for the difficult behaviour of nurses and physicians was lowered; the expression of hostility was overt. One nurse stated:

“You can say, “You haven’t done anything yet tonight, you take the patient.” So nobody actually refuses, they grumble, so it's just, I shouldn’t have to tell them (the lazy nurses). You can get up and just do it. Who has to tell you to take the patient, you just do it. That's annoying, it makes for not a nice atmosphere for work....the more that happens, the more I find myself looking at the schedule to see who I'm working with tomorrow night. It has gotten bad in the last little while because there has been certain nurses laid off and they're coming back on a casual basis or a part time basis, and they're very angry.” (Subject 8)

Furthermore, there was the disappointment in the withdrawal of support from others. There also was the perceived withdrawal of support from administration as this nurse lamented: “She's (nurse manager) always absent from the floor.” (Subject 3) The intrapartum nurses expected the nurse manager to help them on busy days as the previous nurse manager had done in the past. Presently, the expectations of the role of nurse manager were directed by organizational needs as opposed to the intrapartum nurses’ needs which caused some negative feelings amongst the nurses.

The Progression of this Theoretical Process

Although step by step phases were not delineated in this research, it was apparent that the restructuring process was in progress during the interviewing period between April, 1996 and February, 1998. It was not known by the researcher at the outset how health care restructuring would evolve or if it would affect new data. It added an interesting dimension to the labour and delivery nurses' view of their work that was not anticipated. The downward spiral was already in progress when the initial interviews were conducted and proceeded at different rates throughout the research period. The process of spiralling downward was first accelerated when there was a reduction in the nursing staff for the labour and delivery area.
Simultaneously, there was the loss of esteemed colleagues, because of the reduction in the number of staff and the bumping of labour and delivery nurses and replacement of them by staff nurses with less obstetrical knowledge who came from other clinical areas. Later on, the downward spiralling was accelerated again with the arrival of a Nursing Unit Manager who was perceived to be inexperienced in obstetrics. The Nursing Unit Manager met the expectations of the hospital administration which was at times perceived to be in conflict with the expectations of the intrapartum nurses. The nurses had expected the nurse manager to assist the nurses clinically as was done in the past. These two events were deemed as important in that they shaped the intrapartum nurses' environment around their management of childbirth during the downward spiral.

INTEGRATION OF FINDINGS WITH RESEARCH AND LITERATURE

The examination of nursing literature and nursing research pertaining to both intrapartum nursing, and hospital restructuring was conducted. First, the core category of preservative management was compared and contrasted to the findings from a previous study regarding intrapartum nursing. In this section, data derived from American obstetrical nurses (antepartum, postpartum, intrapartum, and administrative) through predetermined questions obtained over 40 years ago (Lesser & Keane, 1956) were compared to findings from this current study. This was the only study found to elicit data from obstetrical nurses themselves. Secondly, recent phenomenological research on American medical/surgical nurses who were in the midst of hospital restructuring (Tillman, Salyer, Corley, & Mark, 1997) was compared and contrasted to the data in this current study.

In the next section, the process, as well as, the six categories and their respective subcategories derived from this study were compared and contrasted to existing intrapartum nursing and hospital restructuring research. In addition to Lesser and Keane's study (1956), studies utilizing time-
sampling and work-sampling to study intrapartum nurses, obstetrical staff/childbearing women interaction studies, and data derived from reports from childbearing women were compared and contrasted to data in this study. Research and literature pertaining to the effects of restructuring on nurses, administration, and job satisfaction were examined, and subsequently, compared, and contrasted to data reported in the current study.

Research and Literature Pertaining to the Basic Social Process of
Preservative Management

Preservative management, as mentioned previously, pertained to the basic social process labour and delivery nurses in this restructuring context experienced when caring for childbearing women. There was a dearth of literature on labour and delivery nurses' perspectives regarding their work. The only data that may be considered as relevant to be compared with the data generated in this study were data derived from the study conducted by Lesser and Keane (1956) in which the sample consisted of a heterogenous mix of 37 nurses (antepartum, postpartum, intrapartum, and administrative) over 40 years ago in a large American hospital. In Lesser and Keane's study, the process of restructuring was not present. However, these nurses answered investigator-contrived, predetermined questions that pertained to their job in an "intensive" interview. The main response chosen by these subjects was that they gained satisfaction in being efficient organizers of obstetrical care and in being dependable allies to a doctor. The findings in that study did not portray labour and delivery nurses as managers of childbirth with the intention of preserving what the individual nurses considered important to a positive experience in childbearing as the nurses were portrayed in this current study. What was similar in both Lesser and Keane's study and in this current study, was that both groups of nurses were of the opinion that safety of the delivery was worth preserving, although Lesser and Keane did not
report it in these terms. The wide variation in what nurses considered worth preserving in the experience of childbirth was not revealed in the Lesser and Keane study. The method of using predetermined questions as a basis to conduct the interview may have eliminated the opportunity for labour and delivery nurses to voice their differing perspectives in the birth experience and how they went about managing the birth experience according to what they perceived as desirable to retain in the process of childbirth. Just because data derived from the obstetrical nurses via preset interview questions did not give rise to the issue of preservative managing in childbirth, we cannot state that managing childbirth in order to preserve what the nurses deemed was positive in childbirth was absent in experience of nurses of that time.

There is little research examining the effects of restructuring on the nurses' work life. However, one phenomenological study (Tillman, Salyer, Corley, & Mark, 1997) documented 9 medical/surgical nurses' perspectives regarding the impact of restructuring in three American hospitals was found. In that study the predominant theme derived from interviews with those nurses was the ineffective buffering of disruptive forces in the environment. No studies were found to depict the effects of restructuring in an obstetrical area on nurses and their provision of care to compare with these perspectives. In this study the primary phenomenon was ineffective buffering of disruptive environmental forces, and the eight themes that emerged from the data reflected the "perceived impact of environmental turbulence on staff nurses' ability to provide patient care." (Tillman et al., 1997, p. 17) It could be postulated that an analogy exists between preserving the nurse-determined positive aspects of childbirth and preserving quality patient care (which could be the equivalent in the medical/surgical areas of nursing) within the context of diminishing hospital resources. However, whereas striving to maintain quality patient care was apparent in this current study's transcripts, in Tillman's report the concept of attempting to maintain quality patient care
was not mentioned. Almost all of the nurses’ data were related to dealing with the frustrations encountered in a non-supportive hospital environment rather than being patient-focused. The nurses worried about how the "environmental turbulence" would affect their relationships with physicians and their performance evaluations. The one exception was worrying about how the patient would be affected by early discharge.

The settings in Tillman’s study were three American mid-Atlantic hospitals that differed in size and population served and were undergoing major corporate level reorganization. The American structure of health care delivery is significantly different from the Canadian model. Furthermore, the restructuring changes in this current study were continuous and insidious, whereas the nurses in Tillman’s study embraced dramatic change when the three hospitals were taken over by a corporation who was interested in maximizing health care profits rather than patient care. The setting differed in that it involved medical/surgical nursing areas. Therefore, a meaningful comparison cannot be accomplished, and one can only make speculations about the reasons for variations in the affects of restructuring on staff nurses in a specific context.

Research and Literature Pertaining to the Process, Categories, and Subcategories of the Intrapartum Nurses’ Experiences

The findings of this current study and the integration of these findings with previous literature and research pertaining to labour and delivery nurses and their environment will be presented according to the process encountered during hospital restructuring, and the six categories and their respective subcategories that are imbedded in the core category.

The Process of Spiralling Downward

In this study hospital restructuring was depicted as a continuous and insidious process. Several environmental and political events which varied
in the degree of impact upon the quality of the nurses' environment occurred throughout the research period. Events such as a reduced number of nurses per shift, the hiring of a new nurse manager who was not perceived to provide clinical support, and the withdrawal of hospital administrative financial support threatened to undermine the delivery of quality care to women in childbirth.

Upon reviewing literature related to nursing performance in the context of restructuring, no other study was found which characterized the changing hospital environment in terms of spiralling downward. One study (Tillman et al., 1997) which used qualitative methods in an attempt to discover salient themes in the lived experiences of medical/surgical nurses generated data from interviews with nurses after the major restructuring was completed. Possibly because of the dramatic nature of the event, and the fact that the nurses were interviewed once only, post restructuring, no process of restructuring became apparent in that study. Another quantitative study (Salyer, 1995) analyzed the effects of the dramatic changes in the health care environment on 135 randomly selected nurses' performance via a theoretical framework based on the effects of stress on performance and depicted environmental turbulence as a variable with several facets—none of which was considered a process.

In summary, the impact of restructuring on nurses was not depicted as a process in previous research studies whereas in this study the environment was characterized by spiralling downward. Differences which might account for this unique finding in this current project may be due to restructuring in this instance, being an ongoing insidious, seamless process interspersed with traumatic events which episodically projected the vortex spiralling downward more quickly. Also, the fact that half the participants took the opportunity to participate in two interviews allowed the comparison of their interviews' content to reflect a process over time.
Research and Literature Pertaining to the Category of Comparing and Contrasting Satisfaction

Comparing Satisfaction in Terms of Previous Experience in Labour and Delivery versus Other Clinical Areas

As literature on restructuring related to obstetrical nurses' job satisfaction is non-existent, the literature related to intrapartum nurses' perception of job satisfaction will be compared. Only Lesser and Keane's (1956) study previously has addressed the issue of intrapartum nurses' job satisfaction. In Lesser and Keane's study they found that the nurses derived job satisfaction from protecting the patient from danger, and doing things that were important to the patient's well-being. In this current study, the notion of keeping the patient safe, and providing support contributed to intrapartum nurses' satisfaction and hence corroborates Lesser and Keane's findings. Additionally, the nurses in Lesser and Keane's study preferred working in the labour and delivery room over other clinical areas, including other areas of obstetrics. Therefore, this finding parallels the current study's finding that intrapartum nurses have a special affinity for the labour and delivery area rather than other clinical areas of the hospital. However, the nature of the current nurses' comparisons of satisfaction in the later period of restructuring consisted of nurses comparing their dampened state of satisfaction with intrapartum nursing to a former level of satisfaction while working in labour and delivery rather than to the lower level of satisfaction expected or found when working in other clinical areas. This finding is new and not known to be documented elsewhere in the literature.

Some distinctions in sources of job satisfaction were found between Lesser and Keane's study and this current study. The nurses in Lesser and Keane's study gave reasons of enjoying the rapidly changing scene, and feeling indispensible to the patient and doctor as the basis of their preference for the labour and delivery clinical area. While there were some nurses in the
current study who alluded to deriving satisfaction from these sources, the intrapartum nurses in this study reported their main satisfaction was derived from their experience of a sense of accomplishment in achieving the state of healthy baby and a happy mother.

**Dampening of Satisfaction**

The subcategory "dampening of satisfaction" occurred in conjunction with the restructuring process. Therefore the evaluation of satisfaction of nurses in other studies was explored. According to a meta-analysis of variables related to nurses’ job satisfaction (Blegen, 1993), the most strongly related variables to job satisfaction are stress (negatively) and commitment (positively). The study was comprised of 48 quantitative studies which included a total of 15,048 nurse subjects within Canada and the United States. There was no mention of the context of restructuring in these studies.

The nurses in this current study related anecdotes of increasing stress as they recounted increasing times where they had to care for several patients simultaneously, had to care for a greater proportion of complex patients in their assignments, and had to deal with colleagues who were becoming increasingly hostile and vulnerable. As the process of spiralling downward progressed, these were the variables that contributed to increasing amounts of stress, which in turn could have produced a dampening of satisfaction.

The nurses encountered an administration whom they deemed as non-supportive, and non-supportive colleagues, who became increasingly more apparent to the nurses, within the context of an environment that placed little value on the nurses’ contribution to providing care. Former good relationships with the Nursing Unit Administrator were terminated because the new Nursing Unit Administrator did not meet the labour and delivery nurses’ expectations of clinical competence. Relationships with other colleagues sometimes were transformed into negative relationships that gave rise to alienation between labour and delivery staff themselves as well as
between them and administration. Consequently, a corresponding level of dissatisfaction ensued. This current study corroborates Blegen's (1993) findings where the alienation of nurses had a negative effect on nurses' satisfaction.

**Research and Literature Pertaining to the Category of Living with Political Forces**

**Leaving Politics at the Door**

Because there was no previous research done in the area of intrapartum nursing in the context of restructuring, it was difficult to find literature to integrate with the findings in this current study. However, in medical/surgical nurses' perspectives regarding the quality of their nursing care in the midst of restructuring as was ascertained in Tillman et al.'s (1997) study, there was no mention of the fact that they tried to shield the patient from the negative impact of restructuring by leaving politics at the door. In fact, the main theme that emerged was the ineffective buffering of disruptive forces in the environment. The nurses in Tillman et al.'s study absorbed non-nursing functions as the restructuring process proceeded, and these functions were performed at the expense of patient care. Because the nature of medical/surgical event is different from childbearing, the type of relationship occurring between patient and nurse in the medical/surgical context may not be the same that develops between intrapartum nurse and childbearing woman. Consequently, there may be differences in the nurses' motivation in order to protect the relationship by "leaving politics at the door." The strategy of "leaving politics at the door" seemed specific to this current study and was not identified in the one other study found which considered factors impacting on nurses during restructuring.

**Living with Fear and Insecurity**

The restructuring process evident in this current study involved potential job loss, or reassignment to other clinical areas, and ultimately
closure of the labour and delivery unit at this facility. These foreseen events generated fear and insecurity within these intrapartum nurses. I have found that the nursing literature to date which has examined the hospital restructuring process does not address the specific concepts of fear and insecurity. The findings in the study of the nurses’ perception of their turbulent environment (Tillman et al., 1997) related to fear only addressed fear of being reprimanded by physicians and administration for unsatisfactory performance due to diminished resources—both human and material. Fearing job loss and the associated insecurity was not an issue in Tillman et al.’s study.

Mitigating and Adapting to the Deleterious Forces of Politics

As mentioned previously, little research data have been generated on the nurses’ responses to the restructuring process. In Tillman et al.’s study the nurses found themselves unable to buffer the effects of the restructuring process on patient care. The nurses described in an open-ended interview format the effects of massive corporate-level reorganization whereby working with diminished resources and working with fewer staff and support services added stress, frustration, and fear of reprisals from physicians and administrators. In general, the nurses in Tillman et al.’s study agreed that they had to learn to work within the system because of the presence of budget constraints that they were unable to do anything about. There was a sense of powerlessness and this powerlessness was exacerbated by administration’s lack of advocacy for the staff. Both in the current study and in Tillman et al.’s study, there were some attempts at mitigating the political forces of restructuring. The nurses in Tillman’s study documented the demands of the increased work load they were expected to meet and tried to get extra staff based on the documentation they had carried out for 4 months. However, their request for extra staff was denied, and they resigned themselves to working in an impoverished environment as best they could. The nurses in this current study did not document their work load and present their documentation to
administration in order to secure extra staff for labour and delivery. They just tried to cope as best as they could which is illustrated by quotes such as "doing your best" and "doing more with less" that were embedded in the data. Using this strategy alone may have been more appropriate to the situation because they knew that their unit was to be dismantled.

Unlike the nurses in Tillman et al.'s study, the nurses in the current study mentioned strategies such as sacrificing their breaks, working only nights, keeping anger and frustration inside, or lowering their expectations of their ability to provide quality care. These strategies were aimed at mitigating and adapting to the deleterious forces of restructuring.

Research and Literature Pertaining to the Category of Maintaining Safety as Top Priority

Regarding Safety as Non-negotiable

The sole study of obstetrical nurses conducted by Lesser and Keane (1956) found that when subjects were asked "What is your main job in caring for a labour patient?" that most nurses' responses revolved around the activities they carried out which they believed would help ensure a safe outcome for mother and baby. This current study substantiates the findings of Lesser and Keane since these nurses universally mentioned the top priority is a safe outcome for mother and baby. Although the circumstances surrounding the issue of safety in childbirth were not specifically addressed in Lesser and Keane's study, there was the implication that safety also was not a negotiable item, as illustrated by the quote "the nurse may develop a sense of conflict between her "main job" (ensuring safety?) and what she thinks patients are looking for at the time." (p. 134)

The nurses in this current study expanded on that theme and frequently mentioned or implied that safety was non-negotiable and any threats to compromising safety were to be dealt with even if it meant disagreeing with
the patient's wishes or ignoring other demands on the unit. If safety or satisfaction has to be sacrificed in the childbirth experience, satisfaction was the one surrendered. It was difficult for nurses to imagine childbirth as a positive experience if there is a damaged or dead baby involved. On the other hand, it was believed by some nurses that women were usually happy with their baby and childbirth experience if they went home with a healthy baby, even though their wishes and plans did not unfold as they hoped. Although there was acknowledgment that the childbearing woman may be disappointed in the actual childbirth experience due to unforeseen circumstances, the impetus for dissatisfaction may lie in the variation between the nurse's and woman's perception of what is considered safe in childbearing.

The nurses were primarily concerned with the safety of the fetus and, secondarily, concerned with the satisfaction of the mother. Some nurses indicated that they believed there were mothers who were not as concerned for the safety of their fetus as they were, thereby necessitating intervention by these nurses in protecting the fetus from the uninformed mother. This perception gave rise to the image of two patients who were sometimes in conflict with each other. The findings in this current study concur with Sandelowski's (1988) observation. She asserted that nurses have uncritically integrated reproductive technology into their practice which has generated a sense of fragmentation and separation. Consequently, nurses practice nursing in a manner that is fragmented rather than holistic which may give rise to a conflict between the care of the fetus and the care of the mother.

**Being Vigilant**

The nurses interviewed in Lesser and Keane's (1956) study maintained that accurate and timely assessment of the labouring patient was key to promoting safety. This theme is illustrated by the following passage in Lesser and Keane’s (1956) study:

"Realizing that doctor and patient depend upon their accuracy, thoroughness and skilled judgment in observing the progress of labour,
they know that life and death may hang in the balance if this function is not properly executed. Therefore, they see themselves as busy, responsible people, who are constantly on the alert for any abnormal symptoms the labouring woman may present, and as the ally of the doctor instituting prompt measures for treatment of any possible complications.” (p. 131)

The intrapartum nurses in this current study spoke of “being on your toes” and “being sharp” as behaviours necessary to ensure the safety of the childbearing process. Therefore being vigilant in order to protect the mother and baby from harm and thereby ensuring their safety was corroborated in this current study.

Relying on Technology

Because the previous research derived from obstetrical nurses concerning the labour and delivery area occurred at a time when fetal monitoring was non-existent, epidural anesthesia was not practiced and other technological advances had not yet entered the labour and delivery area, the nurses in Lesser and Keane’s (1956) study did not place emphasis on technology as an ally to promote safety in childbearing. However, the nurses in that study used the available tools of technology such as a fetoscope to watch for fetal distress by checking the fetal heart every 10 to 15 minutes, and checked the patient’s blood pressure thereby giving the nurse a sense of protecting mother and baby from problems.

In this current study, either fetal monitoring at the bedside or central fetal monitoring were regarded as important in ensuring the safe delivery of the baby, and these technologies were employed frequently, sometimes at the expense of patient satisfaction. Since the advent of central fetal monitoring, nurses have believed that they do not always have to be in the room with the patient to ensure safety. This feature allowed nurses to believe that their patient was safe enabling them to become involved in more acute situations where the presence of the nurse is required to give care that facilitates a safe outcome for another childbearing woman. Meta-analysis of the effectiveness of electronic fetal monitoring has revealed that the practice of continuous
fetal monitoring does not improve fetal outcomes but predisposes mothers to unwarranted obstetrical interventions (Thacker & Stroup, 1999). The research on electronic fetal monitoring contradicts the intrapartum nurses' belief that the patient would be safe if the patient's fetal monitor tracing was observed. Despite the research findings on electronic fetal monitoring, this current study indicated that nurses have increased their reliance on technology to give them a sense that the fetus is safe during the process of childbirth that has evolved over the past 40 years.

**Striving to Give Safe Care to all Patients**

Giving safe care to all patients was a common theme in this current study. The intrapartum nurses abandoned their own patients if they considered they would be "safe" on their own and there was someone at the nursing station to watch the central fetal monitoring in order that they could give care that was necessary to the survival of another patient and her baby. Although, the nurses in Lesser and Keane's (1956) study did not explicitly state that this scenario occurred, there were implicit references which could have related to this phenomenon such as: "They see themselves as ready to jump into the fray, snatching a victory over death, as it were, in partnership with the doctor." (p.133) However, in the current study it is clear that nurses regarded the safety needs of other labour and delivery patients as their priority, over their own assigned patient's needs other than safety, when working in the labour and delivery area.

**Research and Literature Pertaining to the Category of Being Challenged Living with Unpredictibility**

Intrapartum nurses in this study frequently described events in the labour and delivery unit that were unpredictable and challenging. Many derived a sense of satisfaction from the unpredictable and challenging aspect of intrapartum nursing, things that made it exciting and not routine or boring. Lesser and Keane's (1956) study found similar themes. For example,
"others (obstetrical nurses) enjoy the drama of the rapidly changing scene, and the always imminent possibility that "something may go wrong," so that prompt decisive action will be called for." (p. 132) Therefore, both this current study and Lesser and Keane's study have similar data where labour and delivery nurses depicted their environment as characterized as unpredictable, exciting, and challenging.

Nursing Complex Patients

Nurses in this current study cited instances where they were required to nurse a complex medical patient who was in the process of childbirth. Many of the nurses found this aspect of their work as challenging because of the seriousness of the patient's condition and the little information provided regarding the condition that they had to work with. The hospital, in which this study was conducted, specialized in medically complex, antenatal patients and the presence of these complex patients in labour and delivery was not typical of other hospitals. No other study was found to generate data pertaining to being challenged by nursing complex patients in labour and delivery.

Making the Difficult Patient Less Difficult

Several nurses in this study appeared to view 'the difficult patient' in terms of an unresolved conflict between the patient's expectations of a satisfying birth experience and the nurses' need to ensure the safety of the birth experience. In these instances of "the difficult patient" it appeared that the patient had taken for granted that childbirth was a safe process, and therefore the patient tended to focus on the other aspects of childbirth which included psychological satisfaction. Nurses, on the other hand did not take the safety aspect surrounding childbirth as a given. Therefore, the nurse strived to maintain safety, sometimes at the expense of the women's satisfaction with the childbirth experience. However, the nurses believed that that was a small price to pay for a healthy baby which was their number one goal.
In this study and in Lesser and Keane's (1956) study, the difficult patient was the one who had definite ideas of how the labour and delivery should progress and did not want to stray from that conception. In Lesser and Keane's study, these women were classified as 'prepared' and the nurses described them as excessively demanding. The obstetrical nurses in 1956 acknowledged the presence of the difficult patient who was described by one nurse as such:

“They're a little bit harder to handle than the others who don't know what to expect, because they feel so important in how much they know about it that they want you to know all about it. It's good for a one-woman nurse (one-to-one nursing), I think, where you can spend your time with her and coddle her along. I think they take more coddling.” (p. 143)

However, instead of coddling the difficult patient, the strategy the nurses in this current study used to make the difficult patient less difficult was by being firm but not rude and conveying the message that the nurse is there helping them have a healthy baby.

**Being Challenged to Maintain Quality Care**

Because of the restructuring process representing the diminished material and human resources present in this current study, nurses were increasingly challenged to maintain quality nursing care to childbearing women. In several instances, only basic care was given to any specific childbearing woman because the nurses were required to care for 3 to 4 women in labour simultaneously. The intrapartum nurses in the current study claimed that they were challenged to give quality care and were frustrated when they could not provide the care that they believed was desired by the patients. Because the hospital the nurses practiced in had approximately 2,500 deliveries per year and they were staffed with 6 nurses per shift except on weekends, one may assume that the occurrence of having to care for 3 or 4 patients at once actually was rare.

In Lesser and Keane's (1956) study, nurses stated that they gave quality nursing care if they were efficient organizers of care, dependable allies to the
doctor, and the guardians of the patient's safety. Although they found that the nurses did recognize that some patients did desire more nursing care than time permitted, the majority of obstetrical nurses 40 years ago did not feel challenged to provide emotional care because they considered it in most instances a frill—something they could engage in if they had time left over after performing assigned tasks. However, there were some nurses who had trouble reconciling their conflict between their assigned tasks which were characterized as things designated by the hospital and doctors that must be done, and the things they recognized that the patient would like them to do. Therefore it appears that after 40 years, the expectations of what is deemed as providing quality nursing care has changed somewhat, that is, from being mostly organization and physician focused in 1956 to almost entirely patient focused in 1997/98. With the advent of this change in focus, being challenged to provide quality nursing care became a significant issue in this current study whereas with a different definition of quality nursing care the issue did not arise in Lesser and Keane's study.

Research and Literature Pertaining to the Category of Providing Support

In a previous research study (Gagnon & Waghorn, 1996) support was defined as "the continuous presence of lay women or midwives from hospital admission to birth, during which time touch and speech were used for comfort, reassurance, and praise." (p.1). In another research study (McNiven et al., 1992) intrapartum nursing support was operationally defined within four categories of care activities: a) emotional support which included the nurses' presence, general chit-chat, and reassurance; b) physical comfort measures such as cool cloths, assisting with bathing or showering, and positioning for patient comfort, massage, and reassuring touch; c) instruction/information which included help with breathing techniques, giving advice, explanations, and interpreting doctors' findings; and d) advocacy which included supporting the patient's decisions and negotiating the patient's wishes with
other team members. The concept of support derived from this study's data corroborates in McNiven et al.'s definition as described above but, as well includes other activities that nurses believed to support women's childbearing abilities as negotiated between the childbearing women and intrapartum nurses.

Women usually come to the hospital to be supported by medical and nursing staff in the childbearing process. In the hospital, the childbearing women expects to not only draw on the expertise and knowledge from the staff assisting them in childbirth, but also to draw advantages from modern medical equipment and pain relief measures. In other words they are there to be supported in any fashion that they and their caregivers deem is appropriate to facilitating childbirth in a safe and satisfying manner.

Indirect support may comprise a significant portion of the nursing care that nurses provided. The nurses did not describe the care they provided in terms of indirect support, but they believed that they were helping the woman achieve their individual childbirth goals, in various ways. Not only did they believe that they provided psychological support, but also provided support based on technical skills. Whether certain technical skills are supportive or not may be determined by the intent of the nurse, the wishes of the childbearing woman, and the manner of which they are utilized. Upon reporting the findings of this current study's matrix to the intrapartum nurses, all of the nurses agreed that indirect support included some technical activities such as providing pain relief. However, the context and specific technical activities nurses provided were not explored in depth with the nurses. There is a dearth of literature available on what intrapartum nurses consider as labour support. However, recently a doctoral student has used a Delphi survey to build consensus among intrapartum nurses in order to determine what intrapartum nurses consider to comprise intrapartum nursing support (Miltner, 1998). In the preliminary results of data analysis of
Miitner's (1998) research, nurses considered, in addition to those supportive activities described by McNiven et al. (1992), that providing pain relief and following a patient in the capacity of a circulating nurse in a caesarean section as supportive. On the other hand, they considered assessment and assisting with technical procedures not supportive.

Support in this research study included supporting the physical and psychological processes of childbirth that enhance and maintain the health of the baby and to a lesser degree, maternal satisfaction. According to the intrapartum nurses, a basic requirement of a successful childbirth experience is a healthy baby. If this prerequisite was not achieved, dissatisfaction, not so much with the actual childbearing process, but the whole situation in general was expected. Support in the form of ensuring safety was deemed as a legitimate source of support as it gave psychological comfort to the childbearing woman knowing both her baby and herself were alright.

**Bringing Confidence into the Room**

The nurses in this current study brought a certain confidence that was derived from the experience and knowledge in childbirth into the room and supported the patient with it. A similar theme was found by Lesser and Keane (1956) and they categorized it as communicating assurance. They described it as such:

“In carrying out her “main job” of observer and liaison person, the nurse recognizes that she is contributing to the woman’s feeling of security in a fundamental way. The nurse’s knowledgeable presence becomes a bulwark against doubt, if she communicates assurance in whatever she does.” (Lesser & Keane, 1956, p. 144)

Bringing confidence into the room was accomplished by the nurse’s confident manner in which she performed care and this subcategory was demonstrated in both this study and in Lesser and Keane’s study. In both studies there were references to the nurse reassuring the patient in generalities such as “everything is fine”, and answering questions with responses that were intended to reassure the patient.
The process of instilling self confidence in the childbearing woman by the obstetrical nurse was not, however, a clearly delineated theme in Lesser and Keane's (1956) study. Similarly, encouraging and supporting the childbearing woman's own childbearing abilities were not mentioned. However, in this current study, nurses described instances where she did give encouragement and emotional support that was intended to bolster the patient's flagging confidence in her own abilities.

**Advocating for the Patient**

Patient advocacy was formally acknowledged and incorporated in the repertoire of nursing roles in the mid-seventies (Hutchinson, 1990). Whether it was formally documented in the literature or not, it existed to some degree in nursing patients. In Lesser and Keane's (1956) study, there were some references provided by their obstetrical nurses that they were feeling torn between what they must do, that is, assigned tasks versus what they would like to do for the patient, that is, "being something" to the patient. Being something to the patient was not expounded on but the notion that it involved patient advocacy was implicit where the nurse was torn between her allegiance to the organization and doctor and her allegiance to the patient. However, the evidence in Lesser and Keane's study did not clearly articulate advocacy.

Nurses who are patient advocates are principled nurses who are non-conformist, have humanistic values, are fully socialized, and recognize that their values of patient advocacy are different from those of the organization (Hutchinson, 1990). The nurses in this current study demonstrated aspects of patient advocacy. In most instances, there was an indirect approach used because of the ramifications of the direct approach, that is, open conflict. Sometimes the nurses stated that they felt helpless when they knew that they should advocate for the patient but were unable to do so, and others just supported the doctor while rationalizing that the doctor was a patient advocate.
too. The manner and degree of patient advocacy that was practiced by the nurses was highly individualistic and appeared to be dependent on the nurses' personality characteristics.

The findings in this current study concur with the results of Hutchinson's (1990) study where 21 nurses participated in indepth interviews in a qualitative grounded theory study. The researcher found nurses used responsible subversion (the basic social-psychological process in Hutchinson's study). Responsible subversion is predicated on patient advocacy theory, and is based on doing what is best for the patient and sometimes violated rules made by the hospital and physicians. The nurses in Hutchinson's study decided the extent of their own responsible subversion and it was described as a complex process that required energy and effort whereas following rules is far easier.

In this current study, patient advocacy included supporting the wishes and desires of the childbearing woman up to the point where it breached what was deemed to be safe by the individual nurse. All of the nurses' self-perception in this current study was that they incorporated the patient's wishes while assisting with the childbearing process. An impartial observer was not present to validate the self-perceptions of the nurses in this study. However, this finding seems in contrast to the findings of Beaton's (1990) study where 30 intrapartum nurses were studied when interacting with women in labour. In Beaton's (1990) study, actual field observations using nonparticipant techniques served to document the nurse and patient interaction. These observations together with verbatim records that were obtained by writing in shorthand at the bedside were compiled and analyzed. The nurses' and patients' dialogue were analyzed according to Stiles Taxonomy of Verbal Response Modes and the data suggested that the nurses a) seldom acknowledged the viewpoint of the childbearing woman as relevant, b) were presumptuous in what the woman was experiencing, and c) failed to ascertain
the patient's perception of the situation. The method of obtaining the findings in Beaton's study is more objective than the self-reports of nurses in this study who believed they frequently acknowledged the viewpoints of childbearing women. Therefore the validity of these nurses' self-reports should be scrutinized.

Informing and Educating the Childbearing Couple

Informing and educating the childbearing couple was not a new finding according to the literature. Some nurses in Lesser and Keane's study reported that they tried to use explanation, that is, talking and answering questions, to get the fearful childbearing woman to face her fear in a concrete way. However, not all nurses in Lesser and Keane's (1956) study acted that way as illustrated in this quote: "Some nurses who apparently do not see themselves in a teaching capacity, may become exasperated with the woman who wants explanation and information." (p. 146). Unlike Lesser and Keane's (1956) study, the nurses in this current study universally regarded themselves as educating and informing childbearing patients and their partners. Additionally, the partners of the childbearing women were educated to support the women in this study and, with few exceptions, were regarded as an important source of support because of their familiarity with their partner. This finding was not apparent in Lesser and Keane's 1956 study where the nurses discussed whether the husband should even be allowed in the room and, those nurses who did support the presence of the husband in labour and delivery did not mention educating the husband. In Klein, Gist, Nicholson, and Standley's (1981) study, which involved time sampling methodology and observation of 40 childbearing couples during labour, fathers were mentioned as an important source of support, especially touching and being a continuous presence, whereas nurses were supportive primarily in the area of talking which may presumably involve teaching and informing. The content of the talking done by the nurses was not expounded on. However, the fact
that Klein et al. (1981) found a) the fathers engaged in touching and being present in the room to a large degree, and b) the nurses' support was primarily classified as talking would corroborate the findings in this current study in which the nurses found it desirable to educate and inform the childbearing couple as needed and to involve the partner as much as possible.

This current study's finding that nurses engage in the performance of educating and informing the childbearing couple in order to support them was also demonstrated in two work-sampling studies (Gagnon & Waghorn, 1996; McNiven, Hodnett, & O’Brien-Pallas, 1992). Of the little support received by childbearing women from intrapartum nurses, the performance of educating and informing the childbearing couple in order to support was a large component of the support the nurses provided (Gagnon & Waghorn, 1996; McNiven, et al., 1992). In other qualitative studies where the perception of childbearing women and the care they received was elicited, the women spoke of receiving information and instruction during their labour and delivery (Bond, Keen-Payne, & Lucy, 1995; Butani & Hodnett, 1980; Callister, 1993; Hodnett & Osborn, 1989).

**Being There/Not Being There**

The nurses in this current study determined that they should be present with the childbearing woman in the instance of a woman in active labour without an epidural; a woman without a supportive partner; a woman who desired her help; or a woman who experienced an event related to safety that necessitated her presence. Additionally, the nurses determined whether they wanted to be with the patient, in other words if they “clicked” with the patient and the nurse found it enjoyable to be with the childbearing woman. Another factor that determined the nurses' presence was the demands of the labour and delivery unit which included documentation, breaks, and most importantly, the acuity of care required by other childbearing women, that is, whether the safety needs of other patients dictated that the nurse would be away from her
own assigned patient's bedside for any length of time. Although results from several studies have demonstrated the benefits of the continuous presence of a professional caregiver during labour and delivery (Hodnett, 1999), literature which presents reasons why nurses are reported to spend little time at the bedside has been reviewed. McNiven et al. (1992) reason that nurses' supportive care seems to be devalued, and is often considered to be unimportant and of low status. Additionally, Sandelowski (1988) asserts that obstetrical intervention and technology promotes an environment of fragmentation and separation that fosters a sense of disconnection between persons, as the patients are viewed as a system of parts rather than holistically.

Some researchers who studied the presence of intrapartum nurses at the bedside suggested that the nurses were supportive when they spent time at the bedside, and implied that they were not supportive if they were absent (Gagnon & Waghorn, 1996; Kirke, 1980; Klein et al., 1981; McNiven et al., 1992). On the other hand, in studies where childbearing women views were elicited, it was reported that nurses were viewed positively when the nurses correctly perceived that their presence was or was not required or desired. For example, the nurses' ability to assess and meet the patient's need for her presence or non-presence has been claimed to be important to the patient's satisfaction (Shields, 1978). Furthermore, it was noted in Field's (1987) study that when there was a congruency between the mother's expectation and perception of the actual time the nurse spent with her in labour, the level of satisfaction was influenced positively. However, nurses cannot provide support if they are not present to assess and provide what they deem as appropriate support. Additionally, almost all women want someone there a majority of the time and a source of dissatisfaction reported by childbearing women is the absence of the nurse (Hodnett, 1999; Mackey & Stepans, 1994).
Being the Person the Patient Needs You to Be

The subcategory of "being the person the patient needs you to be" is a wide ranging one that is dependent on the patient's situation and perception which is determined through interaction with the patient and the nurse. Contrary to studies (Beaton, 1990; Danziger, 1979) that depict the nurse as the person who is orchestrating the labour and delivery process according to hospital and physician-driven expectations and has the childbearing woman conform to those expectations, nurses in this current study perceived that they developed their role, to varying degrees, in concert with the childbearing couple and provided what they deemed as appropriate support that promoted safety and satisfaction surrounding childbearing.

Implicit in this study subcategory is the concept of acceptance of the childbearing woman's behaviour and wishes. Acceptance was present in some nurses in Lesser and Keane's (1956) study, and demonstrated by some of their nurses who recognized individual differences and behaved in a flexible and non-judgemental fashion. However, these researchers depicted some nurses as approaching women in labour according to a preconceived plan based on the type of patient the nurse perceived her to be while ignoring cues that the childbearing woman displayed. These nurses did not acknowledge individual differences. For example, one nurse thought labour pains were the most excruciating pain you could have and she thought that all patients wanted to be out (heavily medicated) (Lesser & Keane, 1956).

"Being the person the patient needs you to be" is not a concept found in the research literature. However, its roots are based in patient-focused care which is a concept found in current nursing texts (Olds, London, & Ladewig, 1992; Reeder, Martin, & Konlak, 1992). Additionally, it succinctly and comprehensively describes the nurse's role that evolves from patient and nurse interaction. As the process of spiralling downward progressed, the nurses believed that patients no longer received "being the person the
patient needs you to be” nursing care. Instead, the nurse became the person the hospital administration and/or the physician needed her to be. The nurses in Tillman et al.'s (1997) study acknowledged that they were working in an environment where priority setting was based not only on what the patient needed but also on what the organization needed. Some nurses in the current study related feelings of frustration in that they were giving nursing time to serve organizational needs which could have been better spent at the bedside.

Providing Indirect Support

Providing indirect support as in performing nursing tasks such as monitoring vital signs, fetal heart monitoring, urinary catheterization, intravenous initiation, assisting with epidural administration, and scrubbing or circulating for caesarean sections, was a fundamental component of these intrapartum nurses' work life. These actions were indirectly related to achieving a healthy baby and, secondly, a satisfying birth experience. Whether this type of care is as valuable as the subconcepts previously discussed in the category of providing support is open to debate and will not be addressed here. Widespread acknowledgement of this type of nursing care as being appropriate to the intrapartum nurse role is demonstrated in current textbooks (Olds, London, Ladewig, 1992; Reeder, Marin, Koniak, 1992).

Research and Literature Pertaining to Engaging in Professional Relationships

Working as a Team

The intrapartum nurses in this current study worked together not only with the childbearing couple, but also with physicians and other nurses. How well they worked together often determined the outcome of the woman's birth experience and the nurses' satisfaction with their job.

The concept of working as a team appears in the literature where the intrapartum nurse, other intrapartum nurses, and physicians work together
in a hierarchical fashion. Nurses and doctors who are working in the labour and delivery unit “behave as members of a team, each with a known part to play. And the delivery unit cannot function without a strong team spirit and everyone suffers when this is lacking.” (O’Driscoll & Meagher, 1986, p. 87)

While the authors of the latter book mention physicians and midwives as the important considerations when engaging in team work, the current study tends to minimize the importance of rank while working as a team during the care of the childbearing woman, thereby promoting a more egalitarian atmosphere than is apparent in O’Driscoll and Meagher’s (1986) text.

The nurses in Lesser and Keane’s (1956) study also spoke of team work, where one of their primary functions was to organize members of the team (doctors, student nurses, auxiliary staff). The following passage explains this process more fully: “In the wheel of complex services set up by the hospital to give optimum obstetric care to each patient, she (the obstetrical nurse) sees herself as the hub upon which the various spokes of the program are focussed.” (Lesser & Keane, 1956, p.132). However, the prevailing idea in their study was that the nurses worked in a hierarchical fashion and the nurses’ actions were directed towards satisfying the doctor by getting things done in preparation for the delivery. Again, the sense of teamwork was primarily construed as a dominant and subservient type arrangement rather than a team comprised of equals. In this current study, six of the eight nurses contended that they had an equal partnership with the doctor and enjoyed the trust and respect that had been accorded them.

Supporting/Not Supporting Colleagues

Colleagues who did not possess a high level of expertise, or were not as highly motivated as other nurses were initially supported or at least their behaviour was tolerated without much complaint from their colleagues. However, as downward spiral of health care occurred, these less than optimal nurses were increasingly disparaged and less tolerated by their colleagues. In
the latter part of the interview period, the nurses described situations where they needed more support from their colleagues and when they did not receive it, disparagement and decreasing levels of tolerance resulted. This finding was not found elsewhere in the literature. However, in one study (Bolon, 1997) it was suggested that administrators, when downsizing their hospital staff, should pay attention to the qualities of their employees. Furthermore, it was recommended:

"that hospital managers seek to develop a healthy climate of mutual trust and respect between and among coworkers. Problems and conflicts between coworkers should be addressed quickly and resolutions should be clearly communicated to the involved parties." (Bolon, 1997, p. 239)

In the current study one subject specifically addressed the lack of communication to intrapartum nurses by stating:

"I got report from this particular nurse, and she didn’t tell me anything. I went into a room and I couldn’t find anything. Nobody had told us (that the rooms’ set-up had been changed). I just found everything in this big bucket." (Subject 4)

In this instance the intrapartum nurse was disturbed that two colleagues in tandem with the Nursing Unit Administrator had dramatically changed the location and system of obtaining supplies and this change was not communicated to her.

**Not Being Supported by Others**

Not feeling supported by administration and the new nursing manager became a prominent subcategory in the later phase of restructuring. In the Tillman et al.'s (1997) American study of hospital restructuring, the medical/surgical nurses “perceived that the nursing administrators in their institution were having increasing difficulty being effective advocates for nursing.” (p. 17). This finding concurs with the intrapartum nurses' perception in this study.

Hospitals today may hire administrators that are to perform organizational functions and not be responsible for hands-on clinical
activities. This job description is different from the past where the nursing unit administrator had, on occasion, engaged in patient care. Several nurses in this study did not welcome the change in the nursing unit administrator's duties. Management may wish to take this information into consideration when hiring nurse managers, especially in the time of turmoil and upheaval.

As the reports of the withdrawal of administrative support occurred laments involving job dissatisfaction by the nurses became correspondingly more frequent. This subcategory came into existence after they had lived within the process of restructuring, and were experiencing the old adage "you don't know what you've got till it's gone." Although there is no nursing literature that clearly articulates the withdrawal of support during restructuring, it is implicit because of its association with the withdrawal of quantity and quality of staff as well as material resources. However, there is literature and research pertaining to a nurse manager's characteristics and how those characteristics affect nurses' job satisfaction. Leadership support is shown to increase nurses' job satisfaction (Blegen, 1993; McNeese-Smith, 1997; Sorrentino, Nalli, & Schriesheim, 1992). One qualitative study, conducted in a large American hospital, used a structured interview guide to gather data from 30 nurses from three different units that were experiencing major funding cuts (McNeese-Smith, 1997). The data derived from this study suggested that managers who met the needs of the nurses such as providing inservices, supporting nurses in conflicts with doctors and abusive visitors, and following up on problems were viewed as supportive and thereby increased job satisfaction. Therefore the data from McNeese-Smith's (1997) study corroborates the current study's finding that job satisfaction was promoted through the perceived support of the former nurse manager and suggests that increasing job dissatisfaction in the latter period of restructuring is related to the perceived lack of support from the replacement nurse manager.
Enjoying Autonomy

The intrapartum nurses may work with more autonomy than nurses do in other clinical areas in the hospital. Because of the rapidly changing sequence of events sometimes encountered in labour and delivery, and the lack of time to involve others in decisions to ensure a positive outcome, it is often necessary that the intrapartum nurses act autonomously. The nurses in this study enjoyed the autonomy derived from earning trust and respect from physicians and other colleagues.

Lesser and Keane (1956) also noticed that the intrapartum nurses operated in an autonomous manner and that they gained immense satisfaction from the trust and responsibility placed upon them. Therefore the subcategory of enjoying autonomy is not a new idea. Additionally, it has been reported in the literature that autonomy promotes nurses’ job satisfaction (Blegen, 1993). The data in this current study concurred with these results from other studies that suggest that autonomy is a salient characteristic of the intrapartum nurses’ role and that enjoyment or satisfaction is generated from that sense of autonomy.

Summary

Preservative management of childbirth was a new finding possibly because of the dearth of research and literature pertaining to intrapartum nurses in the context of restructuring. In this study, intrapartum nurses were given the opportunity to express their views in an unstructured format. Because they had not been given that opportunity before, their view of their role in the experience of childbirth had not been uncovered. Furthermore, the process of restructuring and its inherent impact probably made the basic social process of preservative managing more evident.

Research from restructuring and administrative studies did not characterize the impact of restructuring on nurses as an ongoing process.
Restructuring in this current study was depicted as a continuum of spiralling downwards. The earlier period of restructuring was generally characterized as enjoying supportive relationships, deriving satisfaction from giving quality care to patients, and having little difficulty in maintaining safety. In the later period of restructuring, supportive relationships evaporated, satisfaction dampened because of the difficulty in maintaining quality nursing care, and safety was increasingly compromised. Some nurses became angry at administration, whereas others seemed to give relatively little indication that they were dissatisfied with their working environment despite the reduction of staff and resources. The different attitudes and their associated emotions may have had an effect on the data received. These changes which occurred over the period of restructuring were not evident in the previous nursing research literature.

Intrapartum nurses in this study were again shown to have a special affinity to their job. This fact had been documented 40 years ago and is still relevant today. Because the intrapartum nurses had this affinity and valued their role in the childbirth experience, it made sense that they would try to protect it from the negative forces of politics. Attempting to mitigate and adapt to the political forces was a strategy of the preservative managing of childbirth. In addition, a second new strategy which involved leaving politics at the door of the client's room was utilized by the intrapartum nurses.

Maintaining the safety surrounding childbirth had been previously documented in the literature and was again emphasized in this current study. However, in this study it was utilized as an essential strategy to preserve the positive aspects of childbirth.

Providing support in this current study was depicted similarly to other studies (Gagnon & Waghorn, 1996; McNiven et al., 1992) in relation to bringing confidence into the room, advocating for the patient, and educating the woman/couple. However, in this study, one type of nursing care was
designated as providing indirect support, and was conceptualized differently from previous studies in that is was subsumed under providing support. Two new aspects of providing support appeared in this study's data, that is, being the person the patient needs you to be, and being there/not being there. The subcategory being there/not being there illustrated the nurses' perception that there were circumstances where these nurses assumed, based on patient cues, it was more appropriate to not be there for an interval of time. The therapeutic value of the intrapartum nurse constantly remaining with the childbearing woman was queried in the data provided by the intrapartum nurses in this current study.

Interaction studies of obstetrical caregivers and childbearing women generated data that gave the impression that obstetrical staff were not interested in the viewpoint of childbearing women. This current study's data contradicts this view emphatically.

Intrapartum nurses working as a team while enjoying autonomy had been documented in the research literature and the data in this current study corroborated those findings. However, the decline in supportive relationships within the obstetrical unit in the midst of restructuring was not clearly delineated in the previous research literature.

Sometimes the findings reported in previous literature did support aspects of the data in this current study, but on many occasions they did not. However, and more importantly, new current data regarding intrapartum nursing were generated. Because of the depth, richness, and comprehensiveness of data derived from the first person interviews, a greater understanding of the 1998 intrapartum nurses' view of their work life in the context of restructuring has been accomplished.
THE SUBSTANTIVE THEORY, IMPLICATIONS FOR NURSING/ADMINISTRATIVE PRACTICE, RECOMMENDATIONS FOR FURTHER RESEARCH, AND CONCLUDING STATEMENT

The Substantive Theory

Preservative managing was the basic social process that was identified by the intrapartum nurses. In this process the nurses engaged in preservative managing of the childbearing couple during restructuring. The intrapartum nurses were determined to manage the childbirth experience in order to make childbirth a positive experience. They strived to maintain what they considered the positive aspects surrounding childbirth so that, in turn, their own satisfaction within an increasingly hostile environment could be preserved. Their working environment, which included their relationships with other staff, was deteriorating so that their relationship with the childbearing couple became an increasingly precious entity to be preserved.

Preservative managing was imbedded in a continuous process of downward spiralling in which health care restructuring had a negative impact on the hospital environment where they practised. As the process of restructuring progressed, deterioration in relationships with other staff, and coping with deleterious political forces ensued. However, the satisfaction the intrapartum nurses derived from patient care remained relatively intact. The preservative management strategies that contributed to their satisfaction were maintaining safety of the mother and fetus/infant as a priority and providing support to the couple both of which were able to be carried out under challenging circumstances.

Preservative managing was characterized by six major theoretical categories which were: (a) comparing and contrasting satisfaction, (b) living with political forces, (c) maintaining safety as top priority, (d) being challenged, (e) providing support, and (f) engaging in professional relationships. While providing support and maintaining safety as top priority
were constant throughout the restructuring process—probably because these categories' features were deemed to be vital to preserve a positive childbirth experience—changes in the features and intensity of other categories (comparing and contrasting satisfaction, living with political forces, being challenged, and engaging in professional relationships) occurred. The intrapartum nurses engaged in the preservative management of childbirth and found that they were: increasingly challenged to keep the negative forces of politics from impacting on the childbirth experience; having to live with progressively deteriorating relationships with other staff; and devoting increasing amounts of energy to keep their own dampening satisfaction out of the patients' rooms.

Implications for Nursing/Administrative Practice

The results of this current study have implications for a variety of people, including nurses, childbearing women, researchers, and, most notably, administrators. The restructuring process had a significant impact on the nurses' well-being that threatened to affect the quality of care delivered to their childbearing patients. It had taken a toll on morale, and collegial relationships. However, the nurses in this study were determined that it was not going to affect the style of care they provided to their patients and the inherent relationship that developed in providing that care. The means to which this objective was accomplished included the nurses having to endure hardships imposed by the political environment, and devising and implementing strategies that simultaneously protected the patient from the negative forces of hospital politics and enabled the nurses to provide the ideal care they had envisioned for their patients. In order to facilitate this scenario happening, strategies derived from the implications of this research could be devised by not only the nurses, but the administrators, physicians, and childbearing women themselves. These implications are described according
to the category that they have evolved from.

The nurses who choose to nurse in the labour and delivery area seem to have special reasons to do so and their preference should be given consideration when there is hospital restructuring occurring. Moving these highly knowledgable, highly motivated and satisfied nurses to another clinical area to which they may be ill-suited leaves them unhappy, and causes dissatisfaction. Staff dissatisfaction results in negative economic consequences for the hospital, increased sick time, high staff turnover, and the fracturing of caring relationships between staff members (McNeese-Smith, 1996).

The restructuring process caused a lot of instability and clearly caused these nurses distress and, in some, anger. Therefore, administrators need to consider how to support nurses. Administrators may endeavour to devise ways to support the nurses' strategy of mitigating the effects of the political turmoil that threatened to spoil their relationship with the childbearing couple which was important to their satisfaction. However, if the politics were allowed to continue to operate in a negative way, the possibility of loss of that last untouched vestige of satisfaction must be realized. The phenomenon of dampening satisfaction was becoming somewhat evident in the later interviews. Therefore, it would be prudent to recognize the point where political forces are breaching the sanctity of the patient/nurse relationship.

Finally, although 3 or 4 nurses appeared to be hostile towards administration, some nurses who were interviewed in the later stages of the restructuring process appeared to be less affected by the negative political forces. This became evident after comparing their transcripts with other nurses and noticing the lack of negative comments made by these nurses. The personal characteristics of these nurses such as resilience, optimism, proactism, and cooperativeness set these nurses apart. It is these nurses that administration should strive to retain in the process of restructuring. Other
researchers (Bolon, 1997) have corroborated this recommendation. Intrapartum nurses unequivocally asserted that the stated and unstated rules of safety were not to be breached. Once the nurses perceived themselves to be in an unsafe situation, they undertook measures to remedy this situation. Unsafe situations made them feel powerless, subject to litigation, and wanting to leave the nursing profession. Because, in addition to losing valuable staff, breaching safety might make the institution vulnerable to litigation itself, nursing administration might advocate for their nurses when they claim that they are working in unsafe conditions, and ensure, through various measures, that their working environment is safe.

These intrapartum nurses relied heavily on their own powers of observation to quickly assess a situation accurately. Such assessments could mean the difference between a tragic outcome or a healthy baby. Therefore, especially in the times of restructuring, it is an advantage to have experienced nurses at the patient's bedside to make these assessments. If inexperienced nurses are employed in the time of restructuring, they require support in being vigilant from other more experienced nurses who may be unavailable because of their heavy workload, therefore making quick and accurate assessments difficult. This situation may give rise to litigation which is costly to everyone involved.

The intrapartum nurses in this current study, as in Lesser and Keane's study (1956), usually enjoyed the challenges that were presented to them, especially in the cases of a rapidly changing childbearing situation. Therefore, it would seem that the type of person to be employed as a nurse in labour and delivery should be someone who likes challenges and a person who likes unpredictability, not routines. Hence, because of the routine nature of the postpartum unit, postpartum nurses may not have the aptitude or liking for the labour and delivery area and may not be suitable for cross training which has been instituted in many hospitals.
Nurses commented that some of the patients that they were required to care for exceeded their knowledge base or experience and, subsequently, they stated that they felt uncomfortable nursing these complex patients. Therefore, inservices regarding the conditions that the nurses can expect to encounter in labour and delivery may be helpful. Additionally, buddying with a nurse who is caring for a cardiac patient in the ICU may be something worth pursuing, especially since these complex patients are becoming more prevalent in labour and delivery.

The nurses were challenged to negotiate a compromise that included patients' wishes for their birth experience and what the nurse considered safe. The nurses perceived that this situation produced conflict in some instances and caused dissatisfaction for the intrapartum nurses and the childbearing couple. Therefore, it is desirable that the nurse and patient have the same expectations. If possible, it may be prudent for the childbearing couple to investigate what is available in terms of care and expectations in the hospital they plan to go to. If the childbearing couple find their wishes likely not to be respected, arrangements such as electing to be cared for by a midwife or making plans to deliver at a birthing centre may be a better alternative. A better understanding of each other's viewpoint regarding childbirth is a step towards a positive outcome, that is, a healthy baby and a happy childbearing couple.

Intrapartum nurses engaged in support that was comprised of instilling confidence, presence, educating, and advocacy. Additionally, the nurses engaged in indirect support that primarily involved technical aspects of their job. Previous research regarding intrapartum nurses' roles and characteristics consistently depicted intrapartum nurses as efficient and capable care-givers in terms of indirect support but less than adequate in the provision of other types of support. Because the safety of childbirth in hospitals appeared to be taken for granted by childbearing women and society
as a whole, the focus has shifted to satisfaction with childbirth. The research conducted in the past has explicitly and implicitly disparaged nurses for not providing adequate psychological support which was most appreciated by childbearing women. Instead of bemoaning the lack of support provided by intrapartum nurses, nurses might be given positive feedback regarding the provision of all types of support, that is, in some instances, integrated and indistinguishable from each other. If positive acknowledgment of the intrapartum nurses' current activities such as bringing confidence into the room, trying to advocate for the patient in the face of difficulties, and informing and educating the childbearing couple is given, it may serve as a basis to encourage the nurses to supply more satisfying care to childbearing women.

Furthermore, administration should evaluate nurses in regard to the manner and type of nursing care they provide. The first step may be in assessing the individual nurses' childbearing philosophy and their style of managing. The second step may consist of clearly articulating administration's expectation in style or type of intrapartum care to be provided by nurses. Designing an environment that supports administration's vision of nursing care to be provided may facilitate the provision of that care. After determining the nurses' philosophy, the quality of care that they provide, and identifying their style of managing, comparisons of the care they provide and the care that is shown to be beneficial to childbearing women should be made. Suggestions for improving nursing care may be discussed and negotiated with the nurse and made part of their formal evaluation.

The data in this current study revealed an interesting phenomenon regarding the subcategory being there/not being there. In previous research not being present with the childbearing couple was regarded as a negative event. However, these nurses viewed not being there as sometimes therapeutic. Furthermore, in the subcategory of being there/not being there, there were instances where the data suggested that personality characteristics
of the nurses/patient dyad did not "click." The intrapartum nurses are humans with their own biography and not saints who can accept everyone as likable. However, certain nurses have certain aptitudes and characteristics that enable them to care for certain patients better than other nurses.

The intrapartum nurses valued the respect they received and the collegial relationships they had with physicians and their colleagues. Positive feedback, co-operativeness, and the positive moods of their colleagues were critical to their satisfaction with work in the labour and delivery unit. Therefore, physicians and nurses should be aware of the positive impact of the intrapartum nurses' perception of respect and collegiality has on their everyday working life and encourage more of the same.

The more knowledgable and energetic nurses or "stronger" nurses were required to shoulder the burden of restructuring and the "weaker" nurses persisted in their present behaviour by not being able to take the more complex patients and the heavier patient assignments that the impact of restructuring required of them. Therefore, in face of restructuring, particular attention should be paid to evaluation of intrapartum nurses' abilities and attitudes whereby formal expectations can be communicated and deadlines set in evaluating their suitability as a labour and delivery nurse in these changing times.

The autonomous nature of the intrapartum nurses' work was universally enjoyed by the nurses. Therefore, the intrapartum nurses' autonomy could be encouraged and supported by administration and physicians because it was regarded by them as an important source of satisfaction.

Recommendations for Further Research

This study was intended to serve as a vehicle to illuminate the working life of nurses who care for women in labour and delivery in the 1990s. The
sample in this study was comprised of labour and delivery nurses who were interested in and cooperative about furthering research, and selected from a diminishing sample pool of subjects due to lay-offs. Several of these subjects spoke of colleagues that may not have possessed these attributes. Additionally, the sampled nurses described some of their colleagues in less than flattering terms, such as "lazy", "hostile", and "uncooperative". The nurses who fit these descriptors did not seem to be sampled in this study as far as the researcher could ascertain. Therefore, another study that targeted these types of nurses as well as the types that were sampled in this study may provide a more comprehensive and valid data base.

Not only were these nurses' working lives depicted in this study, responses related to health care restructuring were also elicited. Several nurses who participated in this study appeared to be hostile towards administration. The possibility exists that these nurses were motivated to participate in this research in order to give themselves a forum in which they could air their grievances which may have confounded the data. A natural expression of anger is exaggeration and scapegoating which might have occurred. Therefore, further studies of intrapartum nursing in the context of a stable environment, that is, without the effects of restructuring may be a fruitful area of exploration. The homogeneity of a stable environment might give a clearer picture of what it is like to be a labour and delivery nurse without the confounding effects of restructuring.

The nurses in this study indicated that they had an affinity for labour and delivery and did not wish to work elsewhere. The variety of reasons cited for liking the labour and delivery area included: being challenging, exciting, giving them the opportunity to develop more in-depth relationships with other staff, enjoying the variety the area provided, and being able to participate in a special event in a childbearing couple's life. The intrapartum nurses in this current study, as in Lesser and Keane's study (1956), usually
enjoyed the challenges that were presented to them, especially in the cases of a rapidly changing childbearing situation. Therefore, it would seem that the type of person to be employed as a nurse in labour and delivery should be someone who likes challenges and a person who likes unpredictability, not routines. Hence, because of the routine nature of the postpartum unit, postpartum nurses may not have the aptitude or liking for the labour and delivery area and may not be suitable for cross training which has been instituted in many hospitals. The practise of cross training and placing labour and delivery nurses in different clinical areas requires further investigation to substantiate these assumptions.

Several categories and their respective subcategories yielded a plethora of data that could serve as a basis for further study. For example, in the later period of restructuring, nurses stated that they felt unsafe and were thankful for the presence of central fetal monitoring, even though the implementation of continuous electronic fetal monitoring had been demonstrated to promote unnecessary obstetrical interventions and not affect fetal outcomes (Thacker & Stroup, 1999). The presence of this technology gave the nurses peace of mind when they were drawn into caring for other critically ill obstetrical patients that required their immediate care and skills for life saving measures. Central fetal monitoring is a controversial feature in the labour and delivery area because it is believed by some (Beverley Philp, personal communication, 1998) that nurses will not stay in their patients’ rooms and will sit at the nursing station watching the central fetal monitor, which would detract from them providing quality nursing care. The nurses perceived central monitoring to be not only a safety net for them, it was seen as something unobtrusive that allowed the nurses to leave the patient undisturbed when they believed that the patient needed to rest. Further research concerning central monitoring may be a fruitful area of research.

The category of providing support was so rich in data that each
subcategory could be studied separately to further delineate the details of these subcategories, thereby furthering the understanding of the nature of labour and delivery nurses' work. For example, the intrapartum nurses' meaning of "support" may be a future research area to explore.

The sampled intrapartum nurses' work experience consisted of no less than 6 years experience. It would be fruitful to sample intrapartum nurses who have less experience. Such interviews may yield different data which in turn could be compared to the data of more experienced nurses. Further study may elucidate the differences between experienced and less experienced intrapartum nurses and the impact these differences have when providing nursing care to women in labour and delivery.

Concluding Statement

The findings from this study were generated from 8 labour and delivery nurses who were in the midst of restructuring and facing an uncertain future. The nurses described the basic social process of preservative managing, that is, keeping the experience of childbearing for both intrapartum nurses and the childbearing couple safe from the effects of health care restructuring and other potentially harmful events perceived by the nurses. The nurses viewed themselves as preservers of a positive childbearing experience as they strived to protect the childbirth experience in the face of deleterious political forces and other harm that threatened the well-being of the mother and her baby.

In the midst of health care restructuring, the intrapartum nurses engaged in six categories of preservative managing. Comparing and contrasting satisfaction was an attempt to measure the success of their preservative managing in pursuit of positive childbirth experiences. The components of comparing and contrasting changed during restructuring. Living with political forces was primarily comprised of nursing behaviours designed to ameliorate the impact of these negative forces upon the outcome of
childbirth. As the intrapartum nurses lived in a negative political environment, nurses engaged in maintaining safety as top priority as a management strategy which was a prerequisite to the preservation of a positive childbirth experience. However, as political forces threatened to undermine safety in childbirth, being challenged to preserve a positive childbirth experience became an issue. Additionally, providing support was another management strategy engaged in by nurses and deemed necessary to preserve the positive aspects of childbirth. Finally, engaging in professional relationships was imperative as the intrapartum nurses did not operate alone and needed support from others to engage in preservative management of a positive childbirth experience.

In summary, the intrapartum nurses were challenged to provide quality patient-acceptable support that did not compromise the patient's safety while protecting a positive childbirth experience from the negative political forces. They deemed they had to engage in preservative managing in order to provide a positive childbearing experience for their patients in the time of hospital restructuring. The process of comparing and contrasting former and current levels of their own satisfaction was undertaken to measure the perceived success of their preservative managing.

This study, utilizing grounded theory methodology, has served to provide insight and generate new information regarding the working life of the labour and delivery nurses. It is hoped that this study may improve the care intrapartum nurses provide by its suggestions for improving the environment in which the nurses provide care. The provision of new knowledge to help administrators to achieve that goal may facilitate a more hospitable working environment in which intrapartum nurses can perform preservative managing to their satisfaction.
REFERENCES


Appendix A

Standardized Memo about the Study Distributed to Labour and Delivery Nurses

Dear Colleague:

Hello! My name is Kathy Augustine, a student in the Graduate Department of Nursing Science at the University of Toronto. In addition to being a graduate student, I am currently employed as a labour and delivery nurse at another hospital. I will be conducting a study of the experience of labour and delivery nurses. The purpose of this study is to investigate labour and delivery nurses' perceptions of their job, thereby facilitating the understanding of the labour and delivery nurses' work life. The primary means of obtaining information in this study is through a taped interview.

I will conducting a 15 minute inservice regarding this study in the near future. It will allow me to give you further information and give you the opportunity to ask questions regarding the study. After the inservice, if you do not wish to be selected as a potential interviewee, please tear off the perforated slip at the bottom and deposit it in the marked box in the nursing lounge. If you do not attend an inservice and do not wish to be contacted by the researcher, simply deposit the slip in the box in the nursing lounge. This box will be present in the lounge for approximately 2 weeks after receipt of this memo. If you fail to deposit the slip, it does not mean you have consented to participate in the study.

I will collect the slips from the box and delete those names from the list of potential interviewees. From the remaining names, I will select five names indiscriminately and leave a note for those individual nurses at the nursing station. The note will request that you phone me before the specified time indicated on the note in order that I may provide further explanation of the study over the phone. The decision to listen (or not to listen) to a further explanation will in no way affect your position at work. The same principle applies to your decision whether or not to participate in the study.

I look forward to the opportunity to speak with you. I wish to emphasize at the outset that anything you might say will be considered confidential.

Yours truly,

Kathy Augustine, R.N.
Graduate Student
University of Toronto

________________________________________
I ____________________________, (Name) do not wish to be contacted by the investigator, Kathy Augustine, in regards to this study of labour and delivery nurses.

Date ___________________ Signature ______________________________
Appendix B

Guidelines for Investigator to use in Subject Selection

The following criteria should be present in potential subjects:

1. Be employed either full-time or part-time as a labour and delivery registered nurse at the participating hospital.

2. Agree to be tape recorded or to have notes taken during the interview.
Appendix C

Letter to Intrapartum Nurse Advising her of Being Selected as a Potential Subject

Dear _____ (Name)_____:  

You may recall that you recently received a memo regarding a study about the experience of being a labour and delivery nurse that I am conducting on your labour and delivery unit. Also, you may have attended an inservice acquainting you with this study. The purpose of this letter is to inform you that your name, along with others has been indiscriminately selected from a list of intrapartum nurses. Since your name has been selected, I wish to request that you telephone me in order to allow me to tell you more about my study.

If you would be so kind as to permit me to give you a further explanation of the study, I would ask that you telephone me at home by _____ (date)_____. Your decision to call me for further explanation will in no way affect your position at work and the fact that you have called me by no means implies your consent. You can decide whether or not you want to participate in this study after we have had an opportunity to talk. However, I would truly appreciate your participation in the study.

Yours truly,

Kathy Augustine, R.N.  
Graduate Student  
University of Toronto
Appendix D

Reminder Memo about the Study Distributed to Selected Labour and Delivery Nurses

Dear ____ (Name) ____:

Last week I sent you a letter advising you that you have been selected as a subject for the study “The Experience of Nurses Who Care for Women in Labour and Delivery”. Unfortunately as of yet I have not received a response from you. It may be because you have had other things to think about, or haven’t picked up your hospital mail yet, or simply you don’t want to participate in the study. Please take the time to telephone me to tell me whether or not you would be willing to participate.

Your viewpoint regarding your experience as a labour and delivery nurse is important because it may facilitate better working conditions in the future as well as make it easier for you to provide more satisfying nursing care. Also, it may give you a chance to tell people what you have long been wanting to tell them with the benefit of confidentiality and the respectability of a research forum. I must emphasize that the success of this study is totally dependent on you. I would be ever so grateful to hear from you.

Yours truly,

Kathy Augustine, R.N.
Graduate Student
University of Toronto
Appendix E

Telephone Explanation to be Presented to Potential Subjects

Thank-you for responding to my request to call me. As you know my name is Kathy Augustine and I am the student in the Graduate Department of Nursing Science at the University of Toronto from whom you received the letter. I am conducting a study of labour and delivery nurses' perceptions of their job to better understand their work life. A better understanding of how labour and delivery nurses view their work life ultimately could improve nursing care to women in labour as well as improve working conditions for labour and delivery nurses.

This study will serve as the basis for my masters thesis. The thesis is a requirement of the Master of Science degree. I am conducting the research under the supervision of Dr. J.S. Chapman, Professor, University of Toronto.

The primary source of data in this study is to be obtained from tape recorded interviews with labour and delivery nurses. The interviews are proposed to be up to 1 hour in length and it is anticipated that there will be two interviews per individual within a 6 month period. After all the interview data have been analyzed, the tentative findings will be shared with you in a letter. A follow-up phone call a week after the letter is sent will be made to get your reaction to my interpretation of what the labour and delivery nurses told me. I would like to learn about your experiences as a labour and delivery nurse. I wish to emphasize at this point that your decision to participate in the study will in no way affect your position at work and you have the option to stop any interview or withdraw from the study at any time for any reason.

Since work as a labour and delivery nurse is episodic in nature, I wish to conduct the interviews during a quiet period in the labour and delivery area while you are on duty. I would ask you to inform me of a scheduled working day on which you are willing to be interviewed. If the day is not busy, we will go to a private area to conduct the interview. The interview will be tape recorded. I will phone you at work at the start of the selected shift (approximately 8:00 a.m.) and if it is not busy, I will come to the hospital to conduct the interview. Please note that if the labour and delivery ward becomes busy, the interview will not take place and will be rescheduled. Also, the interview would be discontinued if it became necessary for you to return to the labour floor.

If you wish, you may elect to conduct the interview at your home or a mutually convenient place that is private and free from distractions. You may indicate that preference at the end of the phone call. Please note if this option is chosen, the interview will be conducted on your own time.

I will take the utmost care to ensure that your interview responses remain confidential. Your responses will not be shared with other members of staff or administrators at the hospital. However, I should mention that in the final report of the study, I may use some of the phrases or words that were used by you in the interview to give added meaning or depth to the text. The source of these phrases or words will be kept confidential. The interview transcripts will be identified with code numbers only. Your name will not
appear on the transcribed interview. The code numbers linked to your name will appear on a master list that will be kept in a locked drawer which is privy to only myself during the study. The masterlist, interview transcripts, and tape recordings will be destroyed at the completion of the study.

Participation in the study may offer some indirect benefits. For example, it may be helpful for you to express your feelings about your job. Also, ideas generated may ultimately improve working conditions in the labour and delivery area.

In concluding this explanation I would like to ask if you have any questions or concerns and to thank you for taking the time to listen. Do you have any questions?

If yes, respond.

If not, would you be willing to participate in the study?

If yes, do you have your work schedule for next week? Is there a day you could suggest that I call to enquire if the unit is busy? Or would you prefer that the interview be conducted at home on your own time?

If no, thank-you for your consideration in this matter.

Person to contact about this research:

Kathy Augustine, R.N.
Graduate Student
University of Toronto
Appendix F

Consent Form

Project Title: The Experience of Nurses Who Care for Women in Labour and Delivery

Investigator: Kathy Augustine

Supervised by: Dr. J.S. Chapman
Professor, University of Toronto

I ______________________________ acknowledge that the procedures in the study and the implications of my participation in the study have been explained to my satisfaction by the investigator, Kathy Augustine, R.N. I have obtained a printed copy of the study's telephone explanation and my questions regarding the study have been answered satisfactorily.

I understand the purpose of this study is to facilitate a better understanding of how labour and delivery nurses view their work environment, which may ultimately contribute to improved nursing care delivered to women in labour and to the improvement of the working environment for intrapartum nurses.

I am aware that the primary source of data in this study is to be obtained from tape recorded interviews with myself and other labour and delivery nurses. Also, I am aware that I am expected to participate in two interviews of up to 1 hour each in duration within the next 6 month period. I understand that the choice of interview site, either at the hospital while on duty or at my home on my own time, will be determined by me. If I choose to be interviewed during a scheduled shift in the labour and delivery area, I agree to inform the investigator of the scheduled working day on which I am willing to be interviewed. I understand that the investigator will phone me at work at the start of the selected shift and will ask me and the charge nurse if it is not busy. If both myself and the charge nurse deem it is not busy, I will expect the investigator to come to the hospital and conduct the interview in a private area away from the labour and delivery suite. If the labour and delivery area is busy or becomes busy, I will be allowed to defer the interview to a later date. I understand that I am free to withdraw from the study at any time for any reason.

I understand that after all the interview data have been analyzed, the tentative findings will be shared with me in a letter and I would expect a phone call from the investigator approximately a week following receipt of the letter. I understand the purpose of this phone call is to elicit a reaction to the investigator's interpretation of what labour and delivery nurses have told her.

I have been given assurance by the investigator that she will take the utmost care in protecting my confidentiality. I understand that the interview data will not be associated with my name, and instead, a code number will be used to identify data. Only the investigator and the thesis chair will be privy to the transcript information. I understand I may be able to recognize
illustrative quotations from my interviews in the final report, however, it is unlikely that anyone else would be able to identify the quotes used as my own words. I understand that the tapes and transcripts of the interview will be destroyed at the completion of this study.

I understand that participation in this study is completely voluntary and a decision to participate will in no way jeopardize my position at work. I also understand that there may be no direct benefits to me if I decide to participate.

I hereby consent to participate in the study and consent to have my interview tape recorded or notes taken during the interview.

(Signature)  (Name in Full, Please Print)

(Witness)  (Date)

The person who can be contacted about this research is: Kathy Augustine.
Appendix G
Interview Guide

Interview Question: 1. Please tell me--What it is like for you being a labour and delivery nurse?

Auxiliary Questions: 1. Tell me what your day is like as a labour and delivery nurse.
   
2. What are the things that happen during the day?
   
3. How do you feel regarding these things you have mentioned?

4. What happens during patient interactions?

5. What things do you do in your role as an intrapartum nurse?

Closing Statement

I'm glad I have had the opportunity to speak with you. Thank-you for your time. I will be in contact with you again after I have had a chance to analyze all the participants' initial interviews.

Second Interview

1. Is there anything since our last meeting that you would like to tell me?

2. In the last interview you stated "______________" Could you clarify this point for me, or, could you elaborate on this.

3. Several nurses have told me, "______________" How do you feel about this comment?

Closing Statement

I have truly appreciated your involvement in the study. Please feel free to contact me for any reason. I will mail a copy of the proposed matrix (Appendix I, p. 128) to you in the future that will disclose the findings of the interviews. A follow-up phone call approximately a week after the matrix is sent will be made. Would that be alright with you?
Appendix H

Preconceived Assumptions Regarding the Experience of a Labour and Delivery Nurse

Because I currently work as a labour and delivery nurse, I have several preconceived ideas regarding the experience of a labour and delivery nurse. First, I believe that nurses value their technical skills over their other skills. Additionally, I believe nurses enjoy performing technical tasks over supportive activities.

Secondly, I feel nurses regard themselves as lookouts for impending danger to the health and safety of the childbearing woman and her baby. A healthy baby is the primary goal of their job. A childbearing mother’s satisfaction with her birth experience is of secondary importance, if at all important.

In order to achieve the goal of a healthy baby, I believe the nurse feels that technology is an important ally to her in achieving this goal. Therefore, if she feels she has mastered the technology associated with her job, she will be able to give superior nursing care to her patients. The intrapartum nurse is relatively unaware of the limitations and dangers of the overreliance on technology such as fetal monitors, oxytocin stimulation and epidural anaesthesia. The labour and delivery nurse feels there is an inverse relationship between the amount of technology utilized and the rates of birth morbidity and/or mortality.

The intrapartum nurse may describe her experience in terms of stress, danger, and drama. She may see herself as an active player in averting the perils of labour and delivery. She may regard herself as an active participant in the labour and delivery process and view the patients as passive, having to be “taught the ropes” of childbearing.

Finally, the satisfaction of the intrapartum nurse’s experience may be dependent on the congruency of the childbearing woman’s and nurse’s ideals and philosophy surrounding childbirth. For example, if the nurse and patient both believe childbirth is perilous and obstetrical intervention is viewed positively, the nurse and the patient will derive satisfaction from the childbirth experience.
Appendix I

Matrix Presented to Labour and Delivery Nurses

The Basic Social Process in this study was determined to be 'Preserving the Sparkle'. The sparkle was the enjoyment of caring for the childbearing couple and being a major participant in childbirth. It appeared that you attempted to preserve the enjoyment of your involvement with childbirth throughout the restructuring process, or as the screws tightened on health care. Various strategies were used to preserve the sparkle, and these strategies were found throughout the interview data.

Six main categories were developed in order to depict the life of a nurse who cared for women in labour and delivery in the midst of health care restructuring. The nature of these categories changed or remained the same as the restructuring process progressed. I have divided the phases of restructuring into the 'earlier' phase and the 'later' phase of restructuring. The categories and their respective subcategories are as follows:

1) Comparing and contrasting satisfaction: a) comparing satisfaction with labour and delivery with other clinical areas versus comparing labour and delivery with former times in labour and delivery; b) dampening of satisfaction.

2) Living with Political Forces: a) leaving politics at the door; b) living with fear and insecurity; c) mitigating/adapting to the deleterious forces of politics.

3) Maintaining Safety as Top Priority: a) regarding safety as non-negotiable; b) being vigilant; c) relying on technology; d) striving to give safe care to all patients.

4) Being Challenged: a) living with unpredictability; b) nursing complex patients; c) making the difficult patient less difficult; d) being challenged to maintain quality nursing care.

5) Providing Support: a) bringing confidence into the room; b) advocating for the patient versus the physician; c) informing and educating the childbearing couple; d) being there/not being there; e) being the person the patient needs you to be; f) providing indirect support.

6) Engaging in Professional Relationships: a) working as a team; b) supporting/not supporting colleagues; c) not being supported by others; d) enjoying autonomy.

I hope you understand the meaning associated with the categories and subcategories that I have developed from the data you provided me with. If you require clarification or explanation regarding these categories and subcategories, please do not hesitate to call me, Kathy Augustine.