THE HISTORY AND DEVELOPMENT OF NURSE-MIDWIFERY EDUCATION IN UTAH: 1965-1985

by

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SUPERVISORY COMMITTEE APPROVAL

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This thesis has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

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To the Graduate Council of The University of Utah:

I have read the thesis of Janis Louise Brugel and Lisa Jo Litton in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the Supervisory Committee and is ready for submission to the Graduate School.

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ABSTRACT

The Master of Science in Nursing, Parent-Child Program, Nurse Midwifery tract at the University of Utah was established in 1965. A review of relevant literature, written communications and extensive interviews with 13 faculty and graduates of the program reveals the following ingredients for its success. Aggressive development of clinical sites appears crucial to a strong nurse-midwifery program. Early difficulties with maintaining suitable clinical sites at the University of Utah were overcome by tenacious faculty and adaptive, assertive students. Curriculum had to keep pace with the expanding nurse-midwifery practice scope as well as unforeseen changes in the availability of clinical sites. Concomitant with these efforts faculty and graduates of the nurse-midwifery program lobbied effectively for state legislative reform; this allowed expanded employment opportunities, increased professional autonomy and the added benefit of more clinical sites for students as new graduates were able to initiate a variety of clinical sites in Utah. Other contributing factors included increased federal funding for nursing programs and a supportive administration. No areas of the program were evaluated as being conspicuously weak from the interviews, although concern about faculty turnover and the hiring of University of Utah graduates was expressed. Curricular shortcomings are inevitable in hindsight, and the graduates interviewed lamented the
paucity of elective credits and the lack of instruction in areas such as establishing a practice, education theory and methods and public relations. The program has had a lasting impact on obstetric/gynecologic nursing and medical care in the region and through the continuing efforts of both faculty and graduates will continue to shape the course of nurse-midwifery practice in the United States.
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The authors would not have initiated this research project were it not for the fact that two different parties expressed a desire to see the history of the nurse-midwifery program at the University of Utah written.

The first to excite our interest was the local chapter of the American College of Nurse-Midwives. The authors discovered in the minutes of a Region V Chapter 8 meeting that the chapter wished to encourage and support a graduate student to research the historical development of nurse-midwifery in Utah. While investigating the feasibility of doing so, the authors became aware that an oral history project was being undertaken at the University of Utah, directed by Dr. Gregory Thompson, to record, on tape, the histories of various departments within the university.

We have received a great deal of encouragement and support from Dr. Thompson as well as much needed information about the oral history process. In addition, the transcription of tapes was paid for by the Everett L. Cooley Oral History Project, a cost which we would not have been able to assume. This service was an invaluable aid to the authors when attempting to analyze the data.

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Gail Evans, CNM, was instrumental in guiding us as we explored our, as yet, unformed ideas about what we wished to research and how the topic might be approached. Evans also provided information about the early history of midwifery in Utah as well as sharing her expertise on the history of nurse-midwifery in the state.

Those individuals who consented to be interviewed and then shared not only their time but their valuable recollections and insights on the topic under study have made this whole project not only possible but exciting and stimulating to conduct.

The authors relied heavily on primary sources of information from the personal collections of Dr. Joyce C. Foster and Dean Emeritus Mildred Quinn as well as from the archives of the University of Utah College of Nursing. We wish to thank Dr. Foster, Dean Quinn and the College for making these references available to us.

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CHAPTER ONE

INTRODUCTION

This study proposes to research the historical development and establishment of the oldest nurse-midwifery educational program west of the Mississippi. The University of Utah's graduate nurse-midwifery program within the College of Nursing has been the home of nurse-midwifery education for the state of Utah since 1965. There were "midwife" training programs in Utah prior to the turn of the century. The pioneer midwives of Utah were among the first educated in America. The distinction between midwives and contemporary nurse-midwives is important, both in education and practice.

In 1985 the nurse-midwifery specialty of the Parent-child Graduate Program celebrated its 20th anniversary of quality education in nursing and nurse-midwifery. Officially accredited by both the National League for Nursing and the American College of Nurse-Midwives (ACNM) almost since its inception, the quality of the program is a symbol of the determination of faculty, students and staff to develop and maintain a program which would prosper, change and evolve with the times.

How has the program evolved? What prompted its development? What is the status of nurse-midwifery education and its significance to consumers, the general public? These are some of the preliminary
questions that led to the development of the topic into an historical research study.

The primary purpose of this study was to write a history of nurse-midwifery education in Utah over the past 20 years. This descriptive study examined data related to the above questions and others. Emphasis was on obtaining primary data through interviewing key individuals and through analysis of documents before the data were lost to archiving and analysis because of the death of firsthand witnesses to events, or decay and loss of documents. The aim of two researchers was to focus on achieving two goals. The first goal was to collect, publish and preserve for future reference information about the initial establishment and development of nurse-midwifery education at the University of Utah. This was achieved by recording oral histories through taped interviews. The transcriptions are archived at the University of Utah Marriott Library. The second goal was to present an analysis of the historical data. The synthesis of data is an integral part of any historical study.

Historical research is contextual. In order to understand the educational program being studied, a broad review of the literature was conducted to present the development of nurse-midwifery education and practice within the historical context of the health care delivery system in this country. The specific health professions which were examined are medicine, nursing and midwifery. The literature review covers the period of the "midwife problem," the "decline of midwifery" and the struggle for autonomy as the new profession of nurse-midwifery emerged. Realizing the many struggles midwives have overcome to establish themselves in America places the
successes and difficulties of a contemporary nurse-midwifery educational program in perspective. Thus, understanding the history of the nurse-midwifery profession facilitates an analysis of future trends in nurse-midwifery education and practice in this country.

The methodology chapter follows the literature review, describing the study, the oral historical research process, how the research was conducted and the reasons for choosing to structure the research as it was. Emphasis is on the oral history process, including the development of the data collection and validation for this methodology. The utilization of both primary and secondary written documents obtained through archival research and other sources supplements and supports the oral histories.

The main body of this report is contained within the "Results" chapter which is comprised of four sections. The individuals interviewed yielded information regarding the promptings to start nurse-midwifery education and practice in Utah and throughout the nation. The respondents' involvement and accomplishments, along with their perceptions of important events at the University of Utah, and their impact on the success of the nurse-midwifery program are documented in a logical organized manner.

The final chapter is comprised of conclusions drawn from the data reported, and recommendations for further study.

The following definitions are presented to reduce possible misunderstandings between the term "midwife" and "nurse-midwife" or CNM.
Definitions

Certified Nurse-Midwife
"A certified nurse-midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives" (Rooks & Haas, 1986, p. 9)

Nurse-Midwifery Practice
Nurse-midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management and referral and is in accord with the Functions, Standards and Qualifications for Nurse-Midwifery Practice as they are defined by the American College of Nurse-Midwives (Rooks & Haas, 1986, p. 9).

Midwife
An empirical midwife or "lay" midwife is a nonnurse or nurse who by virtue of some training or experience cares for pregnant women and delivers their babies usually within a home setting. There is no organization or group that nationally regulates education and/or practice of midwives. The state of Utah had a law which regulated lay-midwifery licensure and practice in the early 1900s but this law no longer exists.

Profession
A group of people which has its own body of knowledge, educates and examines its members and governs its membership (Andrews, 1982).
American College of Nurse-Midwives (ACNM)

The professional organization for nurse-midwives in the United States dedicated to "...the improvement of services for mothers and babies, in cooperation with other allied groups..." (ACNM, 1980, p.2). It is autonomous from all other professional organizations and speaks for its membership on issues affecting the education, practice, recognition, legislation and economics of nurse-midwives (ACNM, 1980; ACNM, 1982).

Certification

The ACNM, Division of Examiners, develops and administers a National Certification Examination. This examination is designed to ensure a minimum level of competency for safe and effective practice at the time of entry into the profession (Foster, 1986).

Certification in Nurse-Midwifery

Certification is granted to individuals who (1) are licensed as registered nurses in the United States or its territories, (2) graduated from a nurse-midwifery educational program approved or with approval pending by the ACNM and (3) achieved a passing score on the examination. Those individuals who receive certification from the ACNM are entitled to use the initials "CNM" following their name and may join the professional association (Foster, 1986, p. 14).

State Licensure

A state license is required to practice nurse-midwifery in the state in which the practice is conducted. Most jurisdictions require ACNM certification as a basis for licensure for practice.
Graduate Nurses

This term was used in the early 1900s to identify individuals who completed training in a school of nursing, usually hospital-based diploma programs.

Basic Nurse-Midwifery Education

The education of all nurse-midwives is based on theoretical preparation in the sciences and clinical preparation for the judgement and skills necessary for management and care of essentially normal women and newborns. Nurse-midwifery care, as defined by the American College of Nurse-Midwives includes antepartum, intrapartum, postpartum and/or well woman health care.

The ACNM defines the essential competencies of a nurse-midwife through a document entitled, "Core Competencies: Expected Outcomes in Nurse-Midwifery Education." To become ACNM accredited, nurse-midwifery educational programs must demonstrate that their curriculum will lead to achievement of the core competencies. Therefore, although students may graduate with a variety of degrees or diplomas, the consumer is assured that all nurse-midwives have satisfactorily acquired the competencies necessary for safe and effective practice. (Conway-Welch, 1986, p. 12)

Types of Programs

Three types of educational programs prepare Registered Nurses (RNs) to take the ACNM certifying examination:

A. Basic certificate programs provide all essential components of the nurse-midwifery curriculum as required by the Core Competencies document, but do not grant a degree.

B. Basic graduate programs provide all essential components of the nurse-midwifery curriculum as required by the Core Competencies document and are incorporated into programs of professional studies leading to an academic degree at the
master's or doctoral level. (The University of Utah's Parent-Child Nurse-Midwifery Program is a basic graduate program.)

C. Precertification programs provide selected components of the nurse-midwifery curriculum based on assessed needs of individual students as required by the Core Competencies document. Precertification programs accept as students registered nurses who are graduates of a midwifery educational program not accredited by the ACNM. Most received their basic nurse-midwifery education in another country (Conway-Welch, 1986, p. 12).
CHAPTER TWO

REVIEW OF LITERATURE

The history of nurse-midwifery in the United States is not an isolated phenomenon but is intimately connected to the histories of medicine, nursing and midwifery. For this reason, a review of the historical literature necessitates acknowledgement of the influences of these occupations on the development and maintenance of nurse-midwifery educational programs and on the profession itself. What follows, therefore, is a review of pertinent literature in the fields of nursing, medicine and midwifery with a description of significant historical events which provides an elaborate background for the historical research undertaken.

The Decline of the American Midwife

Women who earned the title of midwife have attended women during childbirth for centuries. Midwives were the primary birth attendants for the large majority of recorded history, yet:

the first 25 years of this century saw dramatic changes in childbirth in the United States. The population of traditional midwives was drastically reduced and the medical specialty of obstetrics gained practitioners and political strength. (Tom, 1982, p.5)

Many historical analyses have sought to discover the reasons for this rapid transition from midwife-attended to physician-attended births, a trend paralleled by a shift from home to hospital delivery.
Following are brief synopses of several authors' analyses of the reasons for these changes which resulted in an abrupt decline in the numbers of practicing American midwives at the beginning of this century.

Litoff (1982) analyzed the decline of midwifery practice and proposed four major reasons for this decline: (a) the physicians argued that obstetrics was a complicated medical specialty requiring the services of the highly trained medical practitioner, (b) midwife opponents (physicians) were better organized and more articulate than midwife proponents, (c) money appropriated for midwifery training and regulatory programs was pitifully small, and (d) a medley of regulatory legislation enacted between 1900 and 1930 contributed to the midwife's downfall. The author noted that immigration restriction laws of the early 1920s resulted in fewer women demanding the services of a midwife. [These laws also resulted in a decline in the numbers of foreign-trained midwives entering the United States (Devitt, 1979b).] Litoff also explained that the declining birth rate from 1921 to 1933 caused more people to perceive the birth of babies as very special events that required the skills of the highly trained physician.

Devitt (1979b) attributes the decline of the American midwife to legislation enacted in several major Eastern cities which outlawed the practice of midwifery or which gradually eliminated the midwife by ever stricter examinations for licensure. In addition, physicians withheld from the midwife the status of a trained professional while arguing that the midwife was too ignorant to be trained as a safe birth attendant. These physicians could also disparage the skills of
a midwife without fear of contradiction because of a lack of statistics upon which to prove or disprove this contention. Devitt also points out that the immigrant origins of most midwives outside the South and the similarly disadvantaged status of the Southern black midwives kept midwives from establishing the schools and institutions necessary to resist the physicians' attack. There were few schools of midwifery in the United States and immigration from Europe supplied most newly trained midwives. When the restrictive immigration acts of 1921 and 1924 cut off this source, the number of midwives in America dwindled drastically. In 1900 the midwife attended approximately 50% of all births but by 1935 only 12.5% of all births in the United States were attended by a midwife (Devitt, 1979a).

Devitt (1979a, 1979b) contributed greatly to the history of American midwives by evaluating the historical events leading to the elimination of the midwife, 1890 to 1935. He found that the quality of both physician and midwife care had more to do with access to training than with the profession to which they belonged. He pointed out that many physicians, due to poor training and their philosophy of interference in birth, offered unsafe care when compared with that given by trained midwives. Devitt cited efforts to deny midwives access to education and supervision as a reason for their eventual elimination and proposed that the elimination of the midwife slowed the national decline in maternal and infant mortality. This author makes it clear that the quality of care given by midwives during the period studied was equal, if not superior to, that given by physicians.
Several authors have proposed that the "professionalization" of medicine, which occurred in the late 1800s and early 1900s, allowed male physicians to break the midwife's traditional hold on the occupation (Arney, 1982; Brack, 1976; Radosh, 1983) while other processes, separate from professionalization, allowed obstetricians to dominate the field in the United States. Brack (1976) described social and cultural factors which combined to give physicians an advantage. These factors included (a) industrialization and urbanization which brought with it poverty and poor health leading to high maternal and infant mortality rates. This led to the construction of hospitals because of the concern of public health factions over these comparatively high mortality rates. In addition, (b) the development of scientific knowledge and medical technology (to which midwives and women did not have access), (c) the high physician-to-population ratio which intensified the competition between midwives and physicians and (d) the political power of medical associations which contrasted with the poorly organized, unrepresented group of American midwives, all contributed to the rise of obstetrics as a medical specialty.

Arney (1982) also saw the decline of the midwife as a direct consequence of the professionalization of obstetrics but in a much broader context. He stated,

The battle for birth was a battle over livelihood but not livelihood in the restricted economic sense of that term. It was a struggle at many levels: a struggle over the control of birth attendance with its economic implications, over the terms and conditions of birth, over the meaning of birth, and over the very experience of women delivering babies. It was a struggle over life as it is organized around the singular event of childbirth. (pp. 21, 22)
Arney points out that midwives could not resist these attempts at control by the medical profession because they were not well organized nor did they have an "institutionally recognized body of knowledge for which they could claim a privilege and which they could use to argue against the approach offered by men" (Arney, 1982, p. 29).

The Twilight Sleep movement of 1914 and 1915 led by middle and upper class American feminist women provides an illustration of the struggle between consumers and physicians over control of the childbirth experience. American women demanded to be put to sleep with drugs during their labors so that they did not have to experience any pain during childbirth. Many physicians objected to women's demands for painless childbirth, not only because they felt it was hazardous for mother and infant, but also because they believed they should be the ones to determine appropriate medical treatment for their clients. Ironically, this consumer-led movement had the ultimate effect of further "medicalizing" childbirth (Reissman, 1983) because Twilight Sleep required more advanced medical technology, only available in a hospital, and it could be prescribed exclusively by a physician. Twilight Sleep also eventually led to greater control over childbirth by physicians because women under the influence of narcotic and amnesic drugs could not participate in childbirth, could not control their own behavior and did not remember anything about the experience of giving birth (Leavitt, 1984).

Brickman (1983) explored the relationship between the Public Health Movement, the medical profession and the demise of the midwife
for the period in American history from 1880-1930. This author concluded that the medical profession resisted attempts of public health factions to upgrade the status of the midwife through training, supervision and regulation because they realized that they would also have to agree to the same control over their profession and to public scrutiny of their practices.

An excellent review of the literature on the history of childbirth in America is presented by Dye (1980). In this review the author states:

Midwives were usually poor, untrained immigrant or black women with low social status and little occupational prestige. American midwives had no professional identity [and] no way to set standards or disseminate knowledge. Their exclusion from formal training kept them in ignorance about forceps, anesthesia, and other obstetrical developments. (p. 103)

The history of the demise of the American midwife makes several things clear. First, one cannot examine the demise of the American midwife without also examining the rise of the medical specialty of obstetrics. This is why the majority of authors who have conducted historical research about American midwifery have also explored the historical beginnings of modern American medicine. Second, lack of access to education at a time when formal medical education for men was being developed had an adverse effect on the American midwife. One reason that women did not have access to education was the Victorian belief that women were frail, in need of protection and not very capable. This belief was used as an argument for discouraging women from studying medicine as well as from practicing midwifery (Brack, 1976). Third, the female midwife lost the battle to attend birthing women because she lacked the power and authority which
physicians were able to command as men with a scientific education. Fourth, middle and upper class women consumers contributed to the redefinition of childbirth as a medical rather than a social event.

The history of the American midwife not only explains how nurse-midwifery came to be introduced in America but also illuminates some of the problems which nurse-midwives have faced as they struggle to be accepted as professionals by the medical and nursing professions, as well as by consumers.

**History of Midwifery**

The history of midwives is the history of women caring for women. There has been a current resurgence of interest in the history of women as one outcome of the Women's Movement which began in the 1970s. The demise of the American midwife in the early 1900s, has been regarded by many feminist authors as a successful attempt by the male-dominated medical profession to eliminate their female competition in order to monopolize the health care of childbearing women (Devitt, 1979a; Donnison, 1977; Ehrenreich & English, 1973; Wertz & Wertz, 1977). These authors interpret the successful attack on the midwife as an example of sexism in action. It is for this reason that many feminist authors of women's history have chosen to write a feminist interpretation of the history of midwives, but they have largely ignored the history of nursing and nurse-midwifery which are also female-dominated professions that have been affected by the medical monopolization of health care. Some feminist authors have tended to overlook the role women, as consumers, played in the medicalization of health care (Riessman, 1983).
Donegan (1978), Litoff (1978), Radosh (1983) and Wertz and Wertz (1977) wrote histories of the American midwife in which they analyzed the factors which contributed to the demise of midwifery in the early 1900s and the concomitant changes which occurred in the meaning and context of childbirth. These authors also studied the development of male-dominated obstetrics which had a very substantial impact on the midwifery profession as well as on childbirth practices. Each author chose a slightly different focus. Radosh examined the legal, social, economic and political factors which led to the decline of midwifery, Donegan was primarily interested in documenting the emergence of man-midwifery, or obstetrics; Litoff, in the history of the American midwife from 1860-present; Wertz and Wertz focused on how Americans have understood and accomplished birth during the past 350 years. The above authors briefly addressed the history of the nurse-midwife in their studies.

Wertz and Wertz (1977) briefly described how the nurse-midwife came into being in the United States while Litoff details the history of nurse-midwifery in more depth. Litoff reported nurse-midwifery history through 1977; therefore, the information is not current. She also noted similarities between the history of midwifery and current struggles within the profession of nurse-midwifery: "For the most part, the forces responsible for the demise of the early twentieth century lay midwife have also worked against the growth and development of nurse-midwifery programs" (Litoff, 1978, p. 143).

The importance of a lack of education for midwives has been stressed by several authors as contributing to their decline (Arney, 1982; Devitt, 1977, 1979a, 1979b; Litoff, 1978; Radosh, 1983). Yet,
the educational system which did exist in America for midwives has not been studied. Litoff (1978, 1982) has written the most thorough analysis of the schools of midwifery and courses in midwifery which were available to women in early America though this was not the focus of the study. She concludes that the educational and training programs available to midwives at the turn of the 20th century were highly inadequate. The history of the Bellevue School for Midwives (1911-1936) by Tyndall (1978) is the only known history of an American school of midwifery. This study focused upon the factors creating some of the major problems in health care: the persistence of mythical beliefs concerning the professional practitioner in midwifery, adverse reactions to the lay midwife in this country and the fallacious belief that childbirth at home is extremely hazardous.

Midwives have played a prominent role in Utah history yet review of the literature revealed one historical study of Utah midwives entitled, "Guardians of the Hearth: Utah's Pioneer Midwives and Women Doctors" by C. Noall. In this study the author describes the introduction of midwives to Utah which occurred in 1847 when Mormon settlers first arrived in Salt Lake City. Among the pioneers was midwife Patty Bartlett Sessions. "Mother Sessions" delivered many babies on the journey from Nauvoo, Illinois, to Salt Lake City and had the special distinction of assisting the first male child born in Salt Lake City into the world. In her lifetime Patty Sessions delivered close to 4,000 babies and was widely known and respected by citizens of Salt Lake City for her work (C. Noall, 1974).

C. Noall (1974) briefly chronicled the lives and work of 14 of the more well-known Utah midwives, featuring Patty Sessions and Zina
D. Young. All of these midwives lived and worked in the late 1800s and early 1900s. None is currently alive. Their stories were told by the author from very meager available records. The author also recounted the lives and careers of six pioneer Utah woman physicians, all of whom traveled out of the state to obtain their medical education in the late 1800s.

Though Noall's historical research is brief and sketchy, the author did illustrate the intimate link between nursing, midwifery and medicine, as practiced by women in Utah. Many of the midwives about whom she wrote were also known as nurses and served to care for the sick. Several of the women physicians were nurses before they sought training as physicians, and many of these women doctors taught courses to women in nursing and obstetrics/midwifery.

Nurse-midwifery took many steps to "professionalize," such as providing nurse-midwifery educational programs at the master's level, just as medicine did during the "midwife debate" of the early 1900s. However, nurse-midwifery is a female dominated profession which springs from the somewhat subordinate female profession of nursing and suffers from a lack of recognition for the contributions made to maternal-child welfare.

History of Nursing

Prior to examining the historical literature relevant to nurse-midwifery, a brief review of the history of nursing will be discussed for its relevance to the emerging profession of nurse-midwifery. Emphasis will be on nursing education as the history of midwifery has revealed that lack of access to education
was a prime factor in the eventual decline of the midwife. In addition, formal education is a step toward the professionalization of any discipline and has been previously examined as a factor contributing to the eventual success of the profession of American medicine. It is proposed that it was also nurses' access to midwifery education that facilitated acceptance of the nurse-midwife.

Ashley (1976) describes the origin and development of nursing education in the United States within hospital schools of nursing. She explains how the exploitation of student nursing labor in the hospital, coupled with the apprenticeship system of education under which nurses were trained, socialized nurses into docile, unquestioning workers who were very loyal to the institution in which they worked. The author examined the ways in which paternalistic hospital administrators and medical doctors hindered the development of nursing education and delayed the "professionalization" of nursing.

The origin and development of undergraduate nursing education in Utah were explored by S. Noall in a doctoral dissertation entitled, "A History of Nursing Education in Utah." The author utilized historical methodology to analyze data obtained from primary sources such as newspaper articles, letters and documents. She explained the close link that existed between nursing and midwifery in the state prior to the initiation of the first school of nursing at St. Marks Hospital in 1894. In fact, Noall states that "nursing was introduced to Utah by midwives who accompanied the first settlers" (1969, p. iv) and points out that in the 1800s midwives were also nurses. There was no recognizable difference in the two occupations.
The first midwives and nurses to settle in Utah were primarily self-taught as there were no educational programs or courses in existence until Dr. Romania Pratt (a Mormon female physician) and her contemporaries began teaching courses in midwifery in the 1870s (S. Noall, 1969). Thus, it was Utah midwives who first had access to formal education. Nursing education was not initiated in Utah until approximately 20 years after midwifery courses were begun.

Though there were three master's programs in nursing in Utah at the completion of S. Noall's study, because they were at the graduate level they were only mentioned briefly by the author. One of these three programs was the Graduate Major in Maternal-Child nursing which included the nurse-midwifery program at the University of Utah.

Nursing education has made great strides in the past few decades, moving out of the hospital schools and into academic settings. There are now many graduate nursing courses, some of which offer Master of Science degrees. Brown (1977) conducted an historical study of master's education in nursing from 1945-1969 in which the significant personalities and elements that helped shape the character of graduate education in nursing were examined. The author also described the major influences in graduate education curricula during the preceding 30 years.

The first nurse-midwifery program to offer a master's degree was Catholic Maternity Institute (CMI) in association with Catholic University of America in 1948, when master's education in nursing was in a very rudimentary stage of development (Brown, 1977). Thus, while nurse-midwives were pioneers in the development of post-graduate education for nurses, because Brown's focus is so broad,
nurse-midwifery education is not mentioned. This study does provide a valuable context from which to study specific graduate programs in nursing and for this reason the broad outlook of the author was helpful to these researchers.

Nurse-midwives are members of a group of nurses functioning in expanded roles, called nurse practitioners. The nurse practitioner movement of the 1960s had a significant impact on the acceptance of nurse-midwifery by nursing, major nursing organizations, and obstetrical communities (Hsia, 1982). A longitudinal study by Sultz, et al. (1983a, 1983b, 1983c) of nurse-practitioner education and practice obtained data from program directors and students in the years 1973, 1977 and 1980. The authors reported trends in nurse-practitioner education, other interesting changes of the 1973-1983 decade, and then compared the characteristics and motivations of students in nurse-practitioner programs across the United States from 1973-1980. While this is not an historical study, it provides a perspective on the changes which have occurred over time in the nurse-practitioner movement and places nurse-midwives in the context of this movement.

Safier (1977) conducted taped oral history interviews with 17 prominent nursing leaders and published her research in a book entitled Contemporary American Leaders in Nursing - An Oral History. The interviewees were selected by the deans and directors of accredited nursing education programs and presidents, executive directors, and chairpersons of professional nursing organizations, and national commissions based on their reputation as leaders in the field of nursing education, administration, research, and practice.
None of the nursing leaders interviewed was a nurse-midwife yet one nurse-researcher has stated,

Nurse-midwives have served [nurses] well. Their mature, intelligent dedication to the public and to their profession makes [the recounting of the history of nurse-midwifery education] one of the proudest chapters in nursing history. (Hiestand, 1978, p. 139)

Bullough and Bullough (1984) offer a partial explanation for the lack of studies addressing nurse-midwifery in the nursing literature when they state:

Nursing history is full of examples of groups of nurses who have set up their own organizations and even their own training centers because organized and official nursing refused to recognize what they did as proper nursing. (Bullough & Bullough, 1984, p. 6)

These authors touch upon the transition from attendance at birth by midwives to attendance by physicians and, in one sentence, introduce nurse-midwives by stating: "Nurse-midwives have reappeared as a real force and have been important in developing birth centers and family rooms" (Bullough & Bullough, 1984, p. 7).

Relationships Between Nursing and Nurse-Midwifery

From 1925, when the first nurse-midwifery practice was established in the United States, until the present, nurse-midwives have faced many obstacles to their professional growth. The most substantive opposition has come primarily from the medical profession, as documented earlier, but nursing has also failed to support nurse-midwives at critical times. This is somewhat puzzling in view of the fact that nurse-midwives are nurses who have obtained additional experience and education in obstetrics/midwifery.

During the 1940s, one perspective of the issue come into focus:
The place and character of clinical specialization within nursing education became an important question for nursing leaders. There was a sharp difference over what should be the nature and scope of a graduate course in obstetrical nursing. Some believed that nurse-midwifery should be the basis of advanced maternity nursing education and that nurse-midwives could safely assume responsibility for all direct care of mother and infant. Others believed that a major in obstetrical nursing should prepare the nurse to assist with maternity care in all health settings but never assume direct responsibility for the care of mother and infant. The emphasis in this kind of an educational program would be on academic studies rather than on preparing master clinicians. (Hiestand, 1977, p. 139)

It was the firm conviction of many nurse-midwives that the intensive nurse-midwifery course offered the best preparation for professional nurses who could then offer maternity care in any setting. There was, however, little nursing support for this idea (Hiestand, 1977, p. 79).

Another illustration of the differences between nursing and nurse-midwifery is evident when their philosophies about pregnancy and childbirth are compared. "The social decision to emphasize in pregnancy the pathological possibilities, rather than pregnancy as a normal biological process, was never really challenged by nursing" (Hiestand, 1977, p. 83) In contrast, nurse-midwives have focused on the normality of the childbearing process and resisted defining pregnancy and childbirth as medical events. This emphasis is highlighted most strongly in the criticisms which many nurse-midwives have made of the interventionist obstetrical practices of many physicians. A normal process such as childbirth, they believe, only suffers from any attempts to intervene inappropriately in its course. Nurse-midwives strive to apply this belief to their practice by
employing fewer obstetrical interventions than physicians (Diers, 1982; Tom, 1981b).

Nursing did not, collectively, support the development of nurse-midwifery. In general, the assessment made by Dye (1983), that "nurse-midwifery's difficulty in making headway was...due in part to the American nursing profession's ambivalence about this new specialty," (p. 105) rings true. Hiestand reflects these same sentiments: "Even though it was a part of the nursing profession, nurse-midwifery was generally viewed with ambivalence by nursing and failed to receive full support from the profession" (Hiestand, 1977, p. 84).

In conclusion, the demise of the American midwife in the early decades of the 20th century was the result of a combination of cultural, social, political and demographic factors. One of the most significant factors was the successful efforts of medicine to professionalize obstetrics as a specialty, and ultimately to gain conscious control over the childbearing market. Not only did medicine succeed in creating a monopoly over childbirth practices, but it also changed the definition of birth as a social event, to birth as a medical event. Nurses as a professional group, also failed to support nurse-midwifery at critical times in the development of the profession.

The Introduction of Nurse-Midwifery Education

The term nurse-midwife was first introduced into the American vocabulary by Dr. Fred Taussig at the second annual meeting of the National Organization for Public Health Nursing (NOPHN) in 1914.
Taussig suggested the establishment of schools of midwifery, admission to which would be limited to graduate nurses (Litoff, 1978). The suggestion to train nurses as midwives came at a time when traditional midwives were rapidly declining in numbers and public health officials were becoming increasingly vociferous about the nation's high maternal and infant mortality rates (as compared with many European countries). Though there was divided opinion within the medical community about the desirability of training nurse-midwives, several leading obstetricians and public health officials felt there were insufficient numbers of physicians to provide adequate maternity care for everyone in the United States. They saw the nurse-midwife as an ideal substitute for physician care, especially in underserved areas (Hsia, 1982; Tom, 1983).

It was not until 1925, however, that Mary Breckinridge, established the first nurse-midwifery service in the United States, Frontier Nursing Service (FNS), in a remote poverty-stricken area of Kentucky. Breckinridge obtained her nursing education in the United States but travelled to England for her midwifery training because no nurse-midwifery programs existed in this country at that time. The nurse-midwives recruited by Breckinridge to work at FNS were British-trained, and many were also natives of Great Britain. Though the FNS nurse-midwives served a very poor, rural population with a high incidence of health problems related to poor nutrition, unsanitary living conditions, limited access to basic health care including prenatal care and crowded living conditions, a dramatic improvement in maternal and infant morbidity and mortality occurred after initiation of the service (Dye, 1983). The success of this
nurse-midwifery service helped persuade the Committee on the Costs of Medical Care, (a committee created in 1927 by 15 leaders in the fields of medicine, public health and the social sciences), to support the development of nurse-midwifery programs (Litoff, 1978).

It was not until 1931, in New York City, that the first American educational program for nurse-midwives was founded: Lobenstine School for Midwifery, to later become amalgamated with and renamed Maternity Center Association. This was largely a result of the efforts of the Committee on the Costs of Medical Care. The initial purpose for educating nurses as midwives was so that they could more adequately train and supervise immigrant midwives (Wertz & Wertz, 1977).

The second United States educational program in nurse-midwifery was begun at FNS in 1939. A major impetus for the development of this program was the impending loss of several of their staff nurse-midwives at the beginning of World War II who wished to return to their native Great Britain to aid in the war effort (Breckinridge, 1952).

The 1940s saw the initiation of two more nurse-midwifery educational programs: Tuskegee Nurse-Midwifery School in Alabama, and Catholic Maternity Institute in Sante Fe, New Mexico. Eight nurse-midwifery programs were initiated from 1950-1969 and one of these was the Graduate Program in Maternal-Child Nursing at the University of Utah in Salt Lake City (est. 1965). The University of Utah program is the oldest nurse-midwifery program west of the Mississippi river. Though a total of 13 nurse-midwifery programs was established in the United States since the first program opened in
1932, only 7 of these remained in operation at the end of 1969 (ACNM, 1984).

In the 1970s, nurse-midwifery programs burgeoned--no less than 15 programs were established from 1970-1979. In December 1983 there were 29 nurse-midwifery programs in existence in the United States; 11 Certificate Basic Programs, 16 Master's Basic Programs, 1 combined RN/MSN, and 1 Doctoral Basic Program (ACNM, 1984). Although American nurse-midwives have increased in numbers they attended only approximately 4% of all births in the United States in 1983 (Adams, 1986). One of the obstacles to continued growth of the profession is the lack of sufficient numbers of educational programs to meet the increasing demand for these health practitioners (Hsia, 1982).

History: Nurse-Midwifery Practice

The first nurse-midwives to practice in the United States provided maternity care primarily to poor women and families, attending births occurring almost exclusively in the home. This is where the need for the services of a nurse-midwife was perceived to be the greatest. Both FNS and Lobenstine Midwifery Clinic, later to become Maternity Center Association (MCA), were originally home birth services. Thus, "[nurse]-midwifery in this country has its roots in poverty, both rural and urban, and in home deliveries" (Tom, 1982, p. 9).

The nurse-midwife practicing in a home birth service had a great deal of autonomy because she or he generally functioned under medical protocols with very little supervision by a physician. This was soon to change, however.
In mid-century, nurse-midwifery was in professional limbo. Hospital obstetrical services were not available for teaching nurse-midwives. Home delivery was vanishing except in depressed areas, and there was no noticeable move to encourage nurse-midwifery services within hospital obstetrical departments. These developments left nurse-midwifery with only the most tenuous hold within the systems of health care and nursing education. (Hiestand, 1977, p. 123)

Nurse-midwifery practice moved eventually into the hospital setting by the 1960s but not without considerable expenditure of energy on the part of nurse-midwife leaders. In 1965 medical support for nurse-midwifery was still neither widespread nor easily acquired. The ultimate effect of moving into an institution which was primarily operated by and for physicians was to limit the autonomy with which nurse-midwives practiced (Ashley, 1976; Hsia, 1982). The significance of this lack of autonomy to the nurse-midwifery profession is made more apparent by the plea of a nurse-midwifery educator in 1977:

We have gone too long practicing in settings where we constantly have to remind the learner that what she was taught in the classroom cannot be implemented in the clinical site because of institutional limitations [emphasis added]. (Beebe, 1977, p. 18)

Accompanying the move from home to hospital has been a shift from exclusively providing services to the poor, to caring for middle and upper class women who have sought out the services of a nurse-midwife (Rooks, 1983). Other recent developments which have served to increase the autonomy with which nurse-midwives practice are access to hospital privileges, direct reimbursement for services by third party payers and legal bases for practice in all but two jurisdictions in the United States (ACNM, 1984).
The nurse-midwifery profession also has its historical beginnings in public health nursing. The first nurses to provide prenatal care to women were visiting or public health nurses; it was public health nurses who sought out nurse-midwifery education so that they could more competently supervise and train traditional midwives; and the first nurse-midwifery educational programs had a public health nursing component. FNS began its work in the hills of Kentucky as a public health nursing service providing prenatal care as well as general health care to families (Dye, 1983).

Nurse-midwives originally organized themselves in a special section for nurse-midwifery within the National Organization for Public Health Nursing (NOPHN). It was within the NOPHN that the first organized attempt to develop a program of evaluation for nurse-midwifery education occurred in 1945 (Litoff, 1977). When a reorganization of the major nursing organizations occurred in 1952 the NOPHN was discontinued. Nurse-midwives initially sought inclusion in one of the two nursing organizations being formed (American Nurses Association, and National League for Nursing) but concluded that the interests of the profession would best be served by forming their own national professional organization. After several years of considering all the options for organization available to them, nurse-midwives founded the American College of Nurse-Midwives (ACNM) when it joined with the Kentucky-based American Association of Nurse-Midwives formed by the nurse-midwives at FNS in 1929. One of the concerns of ACNM has been the need for objective evaluation and rating of educational programs in nurse-midwifery (Litoff, 1977).
Literature Review: Nurse-Midwifery

The literature review revealed only one published historical research study addressing nurse-midwifery education. This study is a doctoral dissertation entitled *Midwife to Nurse-midwife: A History The Development of Nurse-Midwifery Education in the Continental United States to 1965* written by Hiestand (1977). The purpose of the study was to explore the development of nurse-midwifery education in the continental United States from colonial times to 1965. The author examined historical data with three hypotheses in mind. These were: 1) the social role of women was a major factor in the educational pattern developed for midwifery; 2) the "professionalizing" activities of both medicine and nursing influenced the emergence of nurse-midwifery as an occupational role; and 3) the actions of government have had an impact on the development and maintenance of nurse-midwifery. These hypotheses were supported by the findings of the study.

Hiestand recognized the inseparability of nurse-midwifery practice and education and therefore addressed both areas effectively. She also was aware of the influences that medicine and nursing have had over nurse-midwifery and examined these influences in some depth. Hiestand did not obtain any of her information from living participants in nurse-midwifery education, though many were alive at the time of her study. Instead, the author relied on published and unpublished documents to supply the data needed. Reliance on written sources of information can leave gaps in the data as well as alter the picture given of nurse-midwifery education.
Many changes have occurred within the nurse-midwifery profession in the past 20 years. It is for this reason that Hiestand's work must be continued by the writing of a new chapter in the history of nurse-midwifery education from 1965 to the present.

Teasley (1983) conducted a regional case study in Vermont of the changing social organization of the work of birth attendants. The author examined the processes by which nurse-midwives have attempted to professionalize. The focus of the study was on (1) competing claims to occupational jurisdiction by medical doctors, nurse-midwives and lay-midwives, and (2) the processes by which a client revolt (the home birth movement) and client reform movements (in-hospital birth reform) alter the work terrain, creating new opportunities for emerging occupations, such as lay-midwives and nurse-midwives, resulting in conflicts over the division of labor. The primary source of data was interviews with Certified Nurse-Midwives, lay midwives, physicians and others supplemented by a content analysis of written materials (Teasley, 1983).

Teasley (1983), Safier (1977), and C. Noall (1974) each obtained varying proportions of their historical data from oral interviews thus adding a new dimension to their historical research which cannot be obtained from written primary sources. The large majority of historical studies reviewed, however, relied entirely on preserved written documents for data. While it is necessary, in some cases, to rely solely on the written record (because of the nature of the topic being studied or the lack of living first-hand witnesses), this method of obtaining information can be a source of distortion of
facts and perspectives making it more difficult for researchers to formulate conclusions.

None of the authors cited above was a nurse-midwife. They are from such diverse educational disciplines as sociology, history, women's studies and nursing. Their varying perspectives reflect this diversity.

Nurse-midwives have contributed to the research literature about nurse-midwifery education and practice but there have been few historical studies undertaken by nurse-midwives. This is probably a reflection of the small numbers of nurse-midwives in the United States as well as the relatively short history of the profession. The membership of the American College of Nurse-Midwives totaled 2,363 as of February 28, 1985. This figure included 316 student members (Carrera, 1985).

The American College of Nurse-Midwives (ACNM) has had the foresight to chronicle the progress of American nurse-midwives by funding and conducting questionnaire surveys of nurse-midwives for the years 1963, 1968, 1971, 1976-77, and 1982. These surveys have been very comprehensive; however, because of their quantitative nature it is not possible to gain a broader, more humanistic, holistic perspective of the many ways in which people, events and the social milieu have interacted to shape the history of CNMs.

Robinson (1984), Perry (1983) and Tom (1978) are nurse-midwives who have conducted historical research about nurse-midwifery.

Perry explored the origins of midwifery education and practice in Missouri and concluded that "in Missouri, the educated midwives and physicians who supported their endeavors were too few in number
to have an influential effect in counteracting the trend to abolish midwifery" (Perry, 1983, p. 21). Robinson (1984) conducted historical research about the development of midwifery in the American Black community and described the social forces which led to the eventual demise of the black grannie-midwife in the 1940s.

Sally Tom, a CNM and graduate of the University of Utah, conducted biographical research of four pioneers in nurse-midwifery: Lalla Mary Goggans, Rose McNaught, Aileen Hogan and Agnes Shoemaker Reinders. Two of these four women were interviewed, in person, by the author and information about the other two was obtained from their written replies to prepared questions. This information was supplemented by documents from the ACNM archives (Tom, 1978). These biographical sketches, as well as historical background about the development of nurse-midwifery in the United States, have been published in the official publication of the American College of Nurse-Midwives, the Journal of Nurse-Midwifery. The focus in the biographies is on the women and their accomplishments. Their roles as nurse-midwifery educators is addressed only incidentally.

Beebe (1977), Lubic (1982), Rooks and Fischman (1980), and Sharp (1983a) are prominent nurse-midwives who have recently published articles examining nurse-midwifery education and practice trends. Though these are not historical inquiries, they do provide a framework from which to analyze the national issues in nurse-midwifery education and practice which may have affected the University of Utah educational program.

A review of the literature demonstrated a lack of published studies describing nurse-midwifery educational programs in the United
States. It was assumed that an oral history documenting the history and development of the University of Utah's Nurse-Midwifery Program would contribute to knowledge and understanding of the profession. This assumption is supported in the literature by several prominent nurse-midwives.

Warpinski and Adams (1979) emphasized the need for further research about nurse-midwifery education. A study was conducted in order to obtain information about applicants to nurse-midwifery educational programs for admission in the fall of 1977 so that recommendations could be made concerning future planning for nurse midwifery education in the United States. Based on findings of the study, the authors suggested that more nurse-midwifery educational programs should be developed:

Through a combination of findings from this and other studies about nurse-midwifery educational programs concerning society's needs for women's health care providers, curriculum design options, and characteristics of applicants to nurse-midwifery educational programs, nurse-midwifery educators would have more complete information to assist them in planning future nurse-midwifery education. (Warpinski & Adams, 1979, p. 9)

Sinquefield, a Certified Nurse-Midwife, in a 1979 editorial for the Journal of Nurse-Midwifery, discussed the need to establish goals and priorities for the future growth of nurse-midwifery:

There is an urgent need to further increase our numbers through the establishment of additional educational programs, to further develop new models for practice, and to constantly improve and expand our current models. (p. 2)

Before additional educational programs are developed, however, descriptive studies of the successes and pitfalls of existing nurse-midwifery programs should be conducted.
Other nurse-midwives agree that studying past events and drawing interpretations and conclusions from these events can promote continued growth and development of the profession. McKenzie and Vestal (1980) emphasized the importance of futuristic thinking on the developing scenario which may impact nurse-midwifery from the year 1980 to the year 2005. The authors believe that historical researchers have a responsibility, after analysis of their observations, to make broad recommendations or predictions regarding nurse-midwifery education and trends of the profession within the United States:

Clearly, it is not possible to predict absolutely infallible knowledge about the future. However, it is reasonable to derive knowledge from experience that will help to forecast an image of the future. By studying events and forecasting, better ideas can be developed to solve problems and to improve the future of which nurse-midwives are a part. (McKenzie & Vestal, 1980, p. 13)

Several articles in the Journal of Nurse-Midwifery identified nurse-midwifery leaders who influenced the development of the profession and made contributions to nurse-midwifery education. It should be noted that many are "In Memorium" statements of achievements (Beebe, 1979; Sharp, 1983). The present research relied heavily on oral interviews of informants who were willing and able to make their contributions known prior to their death.

Beebe (1979), in her dedication to Mary Irene Crawford, a visionary nurse-midwifery educator and the third President of the American College of Nurse-Midwives (1959-1971), wrote this about the importance Ms. Crawford placed on education:

As Dean of Columbia University School of Nursing until 1976, the graduate program in nurse-midwifery grew in number of students and quality of education. Under Mary's
leadership, faculty were encouraged to carry out her belief that education should be the leader and not the follower of the profession. (Beebe, 1979, p. 37)

This statement directly supports the present historical research by espousing the view that the direction and goals of nurse-midwifery in the present and future are a function of quality educational programs.

Sharp (1983) identified five major concerns related to nurse-midwifery education as identified by the directors of educational programs (90% response rate to a questionnaire). These are: (a) sources of funding for programs; (b) the need to proceed with theory, research, and writing; (c) the need to focus more attention on faculty development and career advancement of individual faculty members; (d) availability of clinical sites; and (e) political activism. The author also outlined four ambiguities identified by the educational directors, and defined them as professional issues characterized by inconsistencies and controversy. They are: (a) some nurse-midwives are accused of departing from the initial intent of promoting the normal childbearing course, (b) the relationship of nurse-midwifery to nursing, (c) the level of entry into nurse-midwifery practice (graduate or certificate), and (d) the relationship of nurse-midwifery to other midwifery groups practicing in the United States. Are these now, or have they ever been, concerns of the Directors (past and present) of the University of Utah Graduate Program in Nurse-Midwifery?

Four research questions emerged during review of the literature to guide the present study. Upon closer evaluation one question was dominant and took the lead focus. The other questions were not
eliminated from the study but were carefully included within this main focus. The lead question was: 1) What factors influenced the success and continuation of a nurse-midwifery educational program? The next two questions incorporated part of the results or responses to the main question relating to faculty and students: 2) How have the teaching-learning styles of nurse-midwifery faculty at the University of Utah facilitated students' growth, performance and confidence as safe, beginning practitioners? and 3) How are modern nurse-midwifery students socialized into their new role or, stated differently, are nurse-midwives prepared to meet the challenges of actual practice upon graduation? The fourth research question moves the reader from the central focus, the actual nurse-midwifery program, to broader issues: 4) How has the nurse-midwifery program at the University of Utah affected private and public practices of nurse-midwifery in Utah?
CHAPTER THREE

METHODOLOGY

The value of research in nursing has been realized over the years with increasing emphasis placed on quantitative methods because of the complexity of research questions posed. The most appropriate research design to study past events and people's involvement and perception of these events is through historical methodology. According to Polit and Hungler (1985):

"Historical research is the systematic collection and critical evaluation of data relating to past occurrences. Generally, historical research is undertaken in order to test hypotheses or to answer questions about causes, effects, or trends relating to past events that may shed light on present behaviors or practices. (p. 130)"

This is what the authors of this study have attempted to accomplish.

Behavioral scientists generally make the assumption that the purpose of research is to ascertain the truth concerning a particular topic of study. The focus of this research was an historical approach to discover "truths" surrounding the development and survival of a 20-year-old nurse-midwifery graduate educational program at the University of Utah, College of Nursing. The goal of historiography, then, is to establish truth (Christy, 1975).

The value of conducting historical research using a qualitative method of analysis clearly addresses the purpose of this study as stated in the introduction. The qualitative historical research
method is important when the goal is to reveal aspects of the
cultural and social heritage of nursing. Leininger believes it would
be exceedingly difficult to document and understand nursing's history
by quantitative methods alone. She remarked that qualitative methods
are more suited to facilitate the study of people over time and
within an open historical perspective, because these methods are
characteristically descriptive, attributional, and dynamic
(Leininger, 1985).

The decision to utilize oral history as the prime methodology
was deliberate. Through studying the history of nursing, present day
nurses can increase their awareness of previous events and
consequences of those events, and thus formulate actions for the
present and future based on the lessons of the past. It was the
authors' intent to record key informants' views of historical events,
including the interplay of how personalities and events shaped and
molded the Nurse-Midwifery Program into what it is today.

The practice of interviewing individuals on tape about their
lives and times in order to collect valuable source material is now a
well-established field in its own right (Nuenschwander, 1976).

Alan Nevins, world-renowned "father of oral history,"
established the country's first oral history project at Columbia
University in 1948. By 1965 there was enough interest in the oral
history method of preserving the past that an association of oral
historians was formed. Since the inception of the organization, the
historians in the group have been somewhat surprised to find their
ranks increased by people from a variety of academic disciplines,
including physicians, anthropologists, sociologists, psychologists, librarians, archivists and educators (Hoffman, 1984).

Hoffman (1984) commented that one of the most interesting forms of oral history is found in the variety of medical projects. She mentions that a number of medical specialties have conducted tape-recorded interviews with the pioneers in the various fields; however, nursing was not mentioned.

For the purposes of this study, Hoffman's definition was used:

Oral history may be defined as a process of collecting, usually by means of a tape recorded interview, reminiscences, accounts, and interpretations of events from the recent past which are of historical significance. (Hoffman, 1984, p. 68)

Allen and Montell (1981) refer to the term oral history in two ways:

It can refer to the method by which oral information about the past is collected and recorded, and it can also mean a body of knowledge that exists only in people's memories and will be lost at their deaths. (p. 23)

Allen and Montell define oral history from that perspective, i.e., "Not only as a method of acquiring information but as a body of knowledge about the past that is uniquely different from the information contained in written records" (p. 23).

Christy, (1975) a nursing historian, evolved two processes for the critical examination of historical data: external criticism and internal criticism. However, external and internal criticism are examined differently when evaluating historical nursing data versus oral history data. The following descriptions of external and internal criticism are specific to the oral history process according to Hoffman (1984).
External Criticism in the Oral History Process

For oral history, the first task is to establish the authenticity and genuineness of the data. For the purposes of this study, documents as well as interviews were used. The researchers investigated the origins of various documents. However, the determination of authorship was easier to establish from the taped transcriptions than from written sources, as one might expect. In most instances original documents and key informants were utilized as primary sources. Key informants who were direct eye-witnesses to an event or situation were sought as subjects. In this sense the oral record has certain advantages over the written document. One advantage is that there can be no doubt as to its authorship.

Internal Criticism in the Oral History Process

The second critical task is to evaluate the worth of the evidence through reliability and validity of the interviews. Critics of the (oral history) process have usually focused on the fallibility of human memory and questioned both the reliability and the validity of data collected in this manner (Hoffman, 1984, p. 68). Historians look at two aspects of internal criticism.

Internal Criticism: Reliability in Oral History

Hoffman (1984) defines reliability "as the consistency with which an individual will tell the same story about the same events on a number of different occasions" (p. 69). Three of our informants had follow-up interviews, which offered them a chance to repeat their story. When faced with an apparent inconsistency in the record, the interviewers were prepared to raise the issue at a second interview.
Even though 10 of the 13 informants were not given an opportunity for a second interview, inconsistencies found by the researchers were generally addressed during the initial interview. This was possible because, as trained oral historians, the researchers had familiarized themselves with the available records and documents on the matter under discussion before the interview was conducted. As more experienced interviewers, there was less hesitation when clarification was needed or when challenging an informant on a particular issue seemed indicated.

Internal Criticism: Validity in Oral History

"Validity refers to the degree of conformity between the reports of the event and the event itself as recorded by other primary resource material such as documents, photographs, diaries, and letters" (Hoffman, 1984, p. 69).

Ultimately, the validity of an oral report cannot really be tested unless it can be measured against some body of evidence, preferably a primary source. If the author or key informant, from either a written or oral source, was an eyewitness, he is considered a primary source. If the author has been told about the occurrence by someone else, the author is a secondary source.

In verifying the accuracy of statements, firsthand accounts by eye or ear witnesses are considered to be the most reliable, but there is no implication that simply because they are primary in nature they are completely reliable. The historiographer must attempt to establish, through careful comparison and testing, whether a statement is a "fact," a "probability," or a "possibility." To establish "fact," the investigator should have two independent primary sources which corroborate. (Christy, 1975, p. 191)

In this study, the researchers not only sought corroboration from printed records but also made systematic comparisons of the oral
histories collected. The means by which a system was devised to make comparisons from one interviewee to the next will be discussed in the next section while describing the oral history process for this project.

The Oral History Process

Literature sources were surveyed to gain a better understanding of not only the processes of oral history, but the actual techniques used to conduct an oral history project successfully. Being outside the researcher's field, a study of the oral history process had to be accomplished before the interviewers started interviewing informants. Oral history techniques and procedures were studied in conjunction with tutoring sessions facilitated by Dr. Gregory Thompson, historian and University of Utah archivist. The literature review chapter illustrates the dearth of written information obtained through the use of this method in the nursing field and specifically in nurse-midwifery. Therefore, the researchers developed a literature review for oral historical methods in nursing, creating a knowledge base from which similar research projects could be built. Resources for managing the collection and analysis of oral historical data can be located in Appendix D.

The interviewers' approach to oral interviews was more than an attempt to discover and document events which occurred. It encouraged narrators to recall their perceptions, thoughts and concerns during the period they were involved with nurse-midwifery in Utah. This included questions about biographical, social and cultural aspects to help uncover the promptings and motivations which
influenced the origin, and continued operation of the nurse-midwifery program at the University of Utah from 1965 to 1985.

**Steps of the Oral History Process**

Recording and measurement of oral histories for this study followed a predetermined process.

1) The first step of the oral history process was the selection of the subjects based on a priority ranking of key people. Those interviewed were selected primarily on the contributions to the program directly as faculty, administrators and/or students. Several graduates of the program were selected because of their contributions or because of their involvement in political issues which facilitated nurse-midwifery practice in the state of Utah. These same graduates frequently made contributions as faculty in the program either as regular faculty or clinical instructors. All but one subject were Certified Nurse-Midwives. Several of the subjects or respondents have remained actively involved with the program over an extended period of time to the present. Throughout this study subjects or interviewees are referred to as respondents or informants. "Graduate respondents" refer to respondents who completed the nurse-midwifery program at the University of Utah.

2) Initial contact with subjects by letter or by phone was accomplished (see Appendix A).

3) Consent was obtained from each participant prior to the interview and included permission for the tape and its transcription to be archived in the Everett L. Cooley Oral History Collection (see Appendix B). Each interviewee was told how the material would be
treated, where it was to be filed and to whom it would be accessible. If the respondent requested that the transcription be closed, a time period for closure was included in the consent form.

4) Each interview was preceded by extensive preparation of topic areas to be covered based on the individual's involvement and contribution to nurse-midwifery in Utah. Preparation for each interview consisted of a literature review pertinent to the topic under study: the history of the educational program in nurse-midwifery at the University of Utah College of Nursing since its inception in 1965. In addition, primary and secondary sources were reviewed for background information regarding the individual respondents and events surrounding their involvement with the nurse-midwifery program. This information was obtained from primary documents and included information about the early history of lay midwifery in Utah in the 1800s and early 1900s.

The data for this preliminary review were obtained from both primary and secondary sources but the majority were primary. These primary documents included manuscripts, letters, notes, memos, newspaper articles, periodicals, diaries, books, minutes of faculty and staff meetings, legal documents pertinent to the Parent-Child program and pictures. The documents used were maintained in the College of Nursing Archives. Other documents utilized were from the personal files of Dr. Joyce Cameron Foster, which spanned the first 11 years of the program's history when Dr. Foster was the program director, and from the personal files of Dean Emeritus Mildred Quinn. These sources contributed to the most significant and reliable primary sources used: oral interviews with key witnesses to the
events in question. Without such preparation and background information, interviewers would have had to rely solely on the interviewee's memory and recall of events and situations.

5) The taped interviews were conducted by one or both researchers between December 1984 and July 1985. (See Appendix C for information about the location of interviews as well as their dates of tenure as faculty or students.) The majority of interviews were accomplished in Utah; however, some interviews were conducted out-of-state by phone or in person. Most interviews were conducted with both interviewers present, which created consistency in data collection, reducing interviewer bias. Had other interviewers conducted the interviews, there may have been greater difficulty in addressing established categories or topics.

From conducting prior interviews, the researchers gained skills in oral history technique and gained knowledge of the topic under study. Each interview was built upon prior sessions. When both researchers were present to interview the informant, careful attention to foster a neutral stance was achieved by one of the interviewers monitoring the interview as the other asked questions. There were several activities to monitor including the tape recorder equipment, the interviewers behavior during the interview, maintenance of a neutral stance and inclusion of pertinent questions to elicit data.

Interviews were conducted using an open format, nonstructured, except for an outline of categories, events and interviewees' contributions during the time of their involvement in the education and practice of nurse-midwifery in Utah. This method was chosen over
using a structured set of questions for each interview. It was assumed the format would offer a greater opportunity for interviewees to respond in their own words, recalling their perceptions as witnesses to events. Open-ended questions were frequently employed to prompt and direct respondents, assisting the respondent to keep on track without pulling her into topics or categories of less significance. Occasionally, this resulted in the interviewee not addressing or covering a topic which the interviewers thought important. Generally, the interviews contain comments relating to the primary issues or categories, events and contributions of this nurse-midwifery program so that comparison and cross-referencing could be accomplished.

6) Labeling of the tapes was in accordance with the stipulations made by the Everett L. Cooley Oral History Project of the University of Utah. The forms utilized to facilitate organization of the oral history data are part of the Everett L. Cooley Oral History Collection which is directed by Gregory Thompson, PhD (see Appendix B).

7) Transcription of the tapes was done by the researchers and/or the American West Center of the University of Utah. The interviewees had an opportunity to review the transcription before it were archived.

8) Review and analysis of the transcriptions and other data with a cross checking of references to names, dates, and events against other interview transcriptions and written primary documents were accomplished.
9) Interpretation of data was the final step. To clarify steps 7, 8, and 9, the researchers will describe a system developed to review, document and analyze the results of the oral history project (steps 7, 8, and 9 above). These steps constitute the synthesis of the data collected.

Christy (1975) labels these steps as "the most difficult part of the historiographer's task..., for synthesis is the procedure of selection, organization, and analysis of the collected data" (p.192). The researchers who conducted this study proceeded in agreement with Christy's description:

...synthesization [is] the process of developing the narrative, and there may be no relationship between the abundance of the data on a particular event or item and the significance of that event or item. Interpretation of the facts is a creative process of the investigator, and the meaning of the facts is not inherent in the facts alone. An overall design, or conceptual framework, is necessary so that the investigator may be assisted in weighing the importance of the material to be omitted or included. (Christy, 1975, p. 192)

The following describes the overall design for the synthesis of the data. Through the oral histories of several faculty, directors and prior students of the particular nurse-midwifery educational program, pertinent categories developed as interviews were conducted. Several themes that emerged as key categories were examined for consistencies or inconsistencies, and interwoven with the literature and other written primary and secondary sources. The themes were further divided into four main topic areas. Each area then developed into a research question.

The transcriptions were reviewed following a detailed coding system to order the data in a coherent fashion. The researchers
utilized the same system, documenting each interview with specific categories defined for each of the four research questions. Four tables were devised to indicate how the material or data from the interviews was coded for each question. (See Appendix E for exact replications of each research question's categories with space available for coding each interview.)

The coding system is relatively simple. For each interview under a particular category, the "counting number" on the tape was noted in the box provided for that respondent. The counting tape number indicated the approximate spot on the tape where the discussion of that particular category began. Of course, overlap of categories occurs in everyday speech patterns. To accommodate this tendency in the data collection, the same tape spot may be indicated two or more times for several different categories in one interview.

The layout of the coding system on large graphic paper allowed for immediate cross-referencing from one interview to the next. This facilitated an increase in validity and reliability through cross-referencing and an increased ability to interpret and analyze content. To presume to make sense of the huge volumes of transcriptions and documentary material without such a tool would have been foolhardy.

The results of the study were reported and discussed through four research questions. This was accomplished by presenting the data for each question by key categories in sections. Each section utilizes the data collected from voluminous oral history transcriptions supported with primary and secondary written documents
from the University of Utah College of Nursing Archives and personal collections of faculty.

Many respondents' perceptions were similar, which allowed for reporting material collectively versus a case study approach. The results were then presented collectively by categories. Overlap was unavoidable when discussing many topics or categories such as faculty, teaching styles and curriculum; therefore categories were grouped into sections for presentation in the Results chapter.

The categories selected for each section were chosen for clarity and brevity in presentation of the data, since the initial categories for the research questions were too broad in scope. These five sections made it possible to present the data in a logical sequence. The order of the sections does not indicate relative importance.

Each research question was found to be well suited for discussion in one of the five sections:

Section I - Overview of the University of Utah's Nurse-Midwifery Program

Section II - a) Curriculum, b) Teaching methods, c) Faculty: Recruitment, Responsibilities, and Role Modeling. (The first research question regarding teaching-learning styles is incorporated.)

Section III - a) Clinical sites, b) students, and new graduate transitions. (The third research question is incorporated: How are modern nurse-midwife students socialized into their new role? or are Certified Nurse-Midwives prepared to meet the
challenges of actual practice upon graduation?)

Section IV - Legislation Affecting Nurse-Midwifery Practice, (The fourth question in incorporated: How has the Nurse-Midwifery Program at the University of Utah affected the practice of nurse-midwifery in Utah?)

These four sections brought the data into a manageable structure for presentation.

As women, as nurses, as nurse-midwifery students, the researchers were aware of the danger of bias. A conscious effort was made to neutralize biases, thus allowing for a more objective historical research project. To begin with, knowledge of the existence of the biases was an important factor. Without this knowledge, prior to the onset of data collection, nothing could have been done to avoid biases impacting adversely on both the collection and interpretation of data.

The means by which biases were handled during the data collection was addressed in the discussion of Step 5 of the oral history process. The researchers were also aware that the same biases could influence interpretation of the data. Patton (1980) speaks on qualitative methods through human observation, emphasizing that human perception is highly selective. Indeed, he states that:

...different people will view the same physical design or object differently. What people "see" or perceive is highly dependent on their backgrounds. Our culture tells us what to see; our early childhood socialization instructs us on how to look at the world; and our value systems tell us how to interpret what passes before our eyes. (Patton, 1980, p. 122)

For the purpose of oral history one could substitute "ears" for eyes and have the same effect on the study. Personal values and cultural
beliefs could inadvertently shape the author's perception and interpretation of the oral history project.

One example of a bias of the researchers which needed to be acknowledged and dealt with during this research project was the following: the researchers have a strong preference for a noninterventive approach to health care of women. This may have influenced how questions were asked about the philosophy of practice and the political and personal differences between the Nurse-Midwifery Program and the University of Utah Hospital OB/GYN Department, especially when the hospital was utilized as a primary clinical site for student experiences.

The researchers dealt with this bias by being aware it existed and monitoring each other during the interviews to avoid stating opinions while asking pertinent questions. Thus, expression of inappropriate personal opinions during interviews and in the reporting of content was avoided. This does not mean that personal values and views were revised or altered in order to complete the research. However, these values were not purposefully expressed, and therefore neither positive nor negative judgements were imposed. Instead, a more neutral approach was taken, to strive to understand phenomena, events and situations as a whole.

The nature of historical qualitative methods blended and integrated well with the researchers' approach to designing and implementing a study. Both required a holistic, humanistic awareness. The researchers make an assumption that human nature cannot be limited to quantitative analysis. The oral history method
allows for broad, open discussion and analysis, appropriate for evaluating a group of individuals such as nurse-midwives.
CHAPTER FOUR

RESULTS

Overview

The clinical specialty in maternal-child nursing was the third graduate area to be established in the College of Nursing in 1965. The new program permitted a major in either the nursing of children or in maternal and newborn nursing (nurse-midwifery). A Master of Science in nursing with a clinical specialty in psychiatric nursing was initiated in 1958 and one in medical-surgical nursing in 1961. Today there are seven clinical specialties in the nursing graduate program at the University of Utah. Students in all majors are registered in the Graduate School of the University and meet Graduate School requirements as well as those of the College of Nursing. The College of Nursing is an integral part of the University of Utah, with the Dean reporting to the Vice President for Health Sciences.

During the past 20 years, there has been a dramatic shift in the educational preparation of nurses in this country. In 1960, 83% of new nurse graduates were trained in hospital based diploma programs; by 1980, 80% of new graduates had been educated in colleges and universities... (Van Ort, 1985, p. 16)

significantly increasing the number of registered nurses receiving college degrees.
Graduate education in nursing has also expanded over the past 20 years.

In 1960, 1,009 United States nurses graduated from 43 master's degree programs in nursing. In the academic year 1981-1982, there were 5,193 graduates from 154 master's degree programs in nursing. (Van Ort, 1985, p. 16)

Establishment of nurse-midwifery programs as a part of graduate education in nursing followed a post-World War II national trend toward placing professional nursing educational programs in institutions of higher education. One such program was the University of Utah's Nurse-Midwifery program offering a Master of Science in Nursing in addition to clinical specialization in nurse-midwifery. The American College of Nurse-Midwives (ACNM) conducted national surveys in 1963, 1968, and 1971. The 1971 study reported, "the greatest increase in educational preparation of nurse-midwives has been on the master and doctoral levels in comparison with former surveys" (ACNM, 1972, p.3). According to two informants, Dean Quinn (1985) and Yeomans (1985), national support for nurse-midwifery was beginning to emerge in the early 1960s.

Mildred Quinn, the Dean of the University of Utah College of Nursing had already started plans for a maternal and child nursing graduate program in 1964 before considering a nurse-midwife component. In fact, from 1964-1966, the College of Nursing was the recipient of Federal planning funds for the improvement of the teaching of maternal and child nursing in the baccalaureate program and development of a master's degree program in maternal and child nursing (University of Utah College of Nursing, 1966-67).
Nurse midwifery education, however, was not proposed as part of the maternal-child graduate program until Joyce Cameron Foster, PhD, CNM, first met with Dean Quinn in 1964 during an interview in which Foster was seeking an undergraduate faculty position. At that time, Dean Quinn asked Foster (nee Joyce Cameron) if she would be interested in developing a graduate maternity nursing program and Foster responded by asking if Dean Quinn had ever considered including nurse-midwifery as a part of the maternity nursing masters program. Dean Quinn was immediately interested, along with the people at the Children's Bureau who were willing to fund this type of program (Foster, 1985a; Quinn, 1985).

On January 18, 1965, a meeting was attended by the College of Nursing Committee on the Graduate Programs and Mrs. Eleanor F. Hawley, Regional Consultant, Children's Bureau. The primary purpose of the conference was to learn whether Mrs. Hawley was in favor of including nurse-midwifery in the proposed program. Mrs. Hawley was very much in favor of developing a midwifery program in this area of the country. She stated that:

...there are fewer than 500 nurse-midwives in the United States and there is a need for them as assistants to obstetricians, in public health research projects, as college instructors, and as nursing consultants in maternal and child health. (University of Utah College of Nursing - Committee on Graduate Programs, 1965)

This program with its nurse-midwifery component is unique in that it was one of five offered in the United States at the time of its inception. Eastern universities which offered nurse-midwifery programs in 1965 were Yale, Columbia, and New York Medical College.
There was also a master's program in nurse-midwifery offered in Santa Fe, New Mexico by the Catholic University of America.

Dean Quinn (1985) and Joyce Cameron Foster (1985a) originated the idea of graduate nurse-midwifery education at the University of Utah and subsequently obtained financial backing from the Federal Children's Bureau - Department of Health, Education, and Welfare. When it was learned that Dr. Irwin Kaiser, Chief of Obstetrics and Gynecology at the University Hospital, was also in support of the program, the greatest obstacles to initiation of the project were considered to be surmounted.

Joyce Cameron Foster functioned in the baccalaureate program as maternity nursing faculty during the 1965 academic year. With the help of Dr. Marie Holley, who later (1970) became the test consultant for the Division of Examiners of the American College of Nurse-Midwives (ACNM), Foster devised a curriculum somewhat on the Yale model, i.e., a 2-year program leading to a Master of Science degree including specialization in nurse-midwifery and the master's thesis.

From its inception, the philosophy of the nurse-midwifery program was consistent with that of the University of Utah, the College of Nursing, and with the philosophy of the ACNM. The purpose of the Maternal and Child Nursing Program was to prepare selected professional nurses to function as clinical specialists in either maternal and newborn nursing, including nurse-midwifery, or nursing of children. One functional area (teaching or supervision) was required for all students in the Maternal and Child Nursing Program. Emphasis on research was apparent in the thesis requirement.
Throughout the 20 year existence of the nurse-midwifery graduate program, the focus of faculty and curriculum has remained on clinical competence and on developing leaders in the field of maternal-child health.

The "Maternal and Child Nursing" major was developed as two separate pathways or specialty areas. The nurse-midwifery program accepted the first group of students (3) in the fall of 1965. The child program accepted students the following fall. Joyce C. Foster was Director of the Maternal and Child Nursing program from its inception and held that position until 1976. Then she resumed directorship in 1985.

One of the first issues Foster dealt with concerned contracting for clinical sites which would provide the appropriate antepartum, intrapartum and postpartum clinical experience for the student, and which adhered to the educational philosophy and purposes set forth by the ACNM. This philosophy requires that nurse-midwifery faculty teach and clinically supervise their students in an environment conducive to collaboration, consultation and/or referral to the obstetrician, as needed, during the nurse-midwives' management of obstetrical care throughout the normal maternity cycle.

The curriculum was organized around the heart of the program, the clinical experience or practice sites. However, in the 1960s and early 1970s, actual clinical services staffed by Certified Nurse-Midwives were almost nonexistent in this country and very few states had laws promulgated for licensure of nurse-midwives. With the support of Dr. Irwin Kaiser, Chief of the OB/GYN Department at the University Hospital, the nurse-midwifery program utilized the
University Hospital's obstetrical clinics and the labor and delivery inpatient unit for clinical experience until approximately 1973-74.

After Dr. Kaiser resigned his position, the nurse-midwifery program never again received the kind of support from the College of Medicine and the OB/GYN Department that they had initially experienced. The faculty and Dean Quinn developed and administered a nurse-midwifery service at Shiprock, New Mexico, where the United States Public Health Service (USPHS), Indian Health Service (IHS) had medical facilities on the Navajo reservation. The service was directed by Lorraine Sevcovic, CNM, University of Utah faculty, who moved to Shiprock to coordinate the service in collaboration with the IHS. For several years nurse-midwifery students utilized the "Shiprock Project" as their primary clinical experience during the summer of their first year of study.

The Shiprock experience became the hallmark of the program and attracted many applicants. Unfortunately, the IHS did not continue its contract with the University of Utah College of Nursing after 1981. Therefore, the nurse-midwifery faculty and administration sought out several other clinical sites, the major site being at Hill Air Force Base Hospital 33 miles north of Salt Lake City. This service contract was actually developed in 1974 but was expanded to accept more students after Shiprock ended as a clinical site. By 1980-81, several graduates of Utah's nurse-midwifery program had begun to develop nurse-midwifery services in Utah including both independent "private" practices, as well as "public" practices, such as services affiliated with the local public health department. Many of these services offered their practice for students to obtain
clinical experiences in full scope nurse-midwifery care, and continue to do so.

Administratively, a major change occurred after Dean Quinn's retirement and the appointment of Dr. Madeleine Leininger as Dean in July 1974. When Leininger resigned in 1979, Dr. Linda Amos became Dean and retains that position today. The structure of the "Maternal and Newborn Nursing" major was changed to a broader title, "Parent-Child Nursing," and incorporated three specialty pathways: the Nurse-Midwifery Program, Perinatal Program and Child Program. This occurred during the 1975-1977 years of accelerated growth and change for the nurse-midwifery program. Margie Freston, CNM faculty, held the position as Acting Parent-Child Director in 1975-76 until Dr. Beryl Peters was recruited in 1976. The current director is Dr. Elizabeth Pugh who accepted the position in 1984.

Within the nurse-midwifery program, major administrative and curriculum changes also occurred during those years, influencing the program's direction and character. After 11 years as Director of the Nurse-Midwifery Program, Joyce Foster resigned the position in 1976 to pursue doctoral studies; however she continued as a faculty member. Sally Yeomans assumed directorship of the program in August 1976. She was succeeded by Lorraine Sevcovic in January 1982 for a 1-year term and Dr. Kelii Sine held the position for a 1-year term in 1983-84. In 1984, the directorship went full circle back to Dr. Joyce Cameron Foster.

It is evident that any graduate educational program is affected by changes in program directors and faculty, for these individuals create, evaluate and recreate the actual curriculum for their
students. Nurse-midwifery graduate education is also affected by additional aspects, such as the availability and accessibility of clinical sites, appropriate licensure to practice as a student or faculty member and as a graduate Certified Nurse-Midwife and availability of malpractice insurance coverage.

Curriculum

This section discusses issues regarding faculty and curriculum. The reader may refer to Appendix C which provides information regarding the periods during which respondents were students or when they functioned as faculty members, directors of the nurse-midwifery program, or in other capacities.

The faculty of the nurse-midwifery specialty believe that the curriculum and clinical experiences must be designed to support the philosophy and the educational criteria established by the American College of Nurse-Midwives. According to the philosophy of Parent/Child Nursing, specialization prepares nurses to be clinical specialists in perinatal nursing or nurse-midwifery. Nurse-midwives manage the care of mothers and babies throughout the normal maternity cycle (Adams & Melson, 1982). This latter statement is consistent with the philosophy of the ACNM.

Elements of administrative leadership, teaching/learning theory and research are integral curricular components. It is the purpose of the nurse-midwifery specialty to prepare candidates eligible to take the ACNM Certification examination and obtain licensure in jurisdictions where such is legal (University of Utah College of Nursing Parent-Child Nursing, Nurse-midwifery Tract 1982, p.1.).
Two faculty respondents who were past directors, Joyce Foster and Sally Yeomans, devoted a great deal of time and energy to their participation in the national ACNM "testing committee" which later became the Division of Examiners in the mid-1970s.

The testing committee was developed in 1969. Ernestine Weidenbach, CNM, Foster's prior instructor at Yale, asked Foster to chair the committee whose purpose was to develop a national licensure examination.

I remember Ernestine very clearly saying that it should be a humanistic exam...It should allow the expression of the kinds of learning that individual had, and not a multiple choice, true-false, kind of exam, because she felt that way it could not be a holistic, comprehensive exam. (Foster, 1985a)

Dr. Marie Holley, a friend of Foster's and faculty member of the College of Nursing, was hired by ACNM as test consultant. At the 1971 ACNM Annual Convention, Foster presented the committee's proposal and it was passed (Foster, 1985a).

Yeomans had a similar commitment to the ACNM. Yeomans was appointed to the faculty in 1971, and took a year's leave of absence in 1975 to act as temporary Executive Director of the ACNM Division of Examiners for 6 months. In addition she served as the Division's chairperson for that year. These two faculty member's involvement with the development of ACNM national certification exams affected the format of tests developed in the nurse-midwifery program, concentrating on essay questions regarding management of care to prepare students for the ACNM examination.

At the time the ACNM testing committee developed the certification procedure and examination in 1971, the ACNM gave
retroactive certification to all nurse-midwives who applied that were members of the ACNM and who had completed one of the accepted recognized programs. There was no formal accreditation or means of accepting or recognizing a program at that time; however, there was simply a network of recognition among the programs (Foster, 1985a).

The ACNM has since developed a formal accreditation process to evaluate nurse-midwifery educational programs according to strict criteria set by the ACNM Division of Accreditation. Once a program is accredited by the ACNM, a formal review process must be completed every 5 years to maintain approval status. The University of Utah received initial ACNM accreditation in 1968 and has continued to hold this status with the last review in 1982. Maintaining ACNM accreditation approval has always been crucial to the program's existence, because without it the program would not have received federal funding.

The nurse-midwifery program was initially designed as a two year course of study offering a Master of Science degree and eligibility to sit for the ACNM Certification Exam, with a minor in either educational psychology or psychology. In designing the curriculum, Foster entered a system at the University of Utah that already had an established pattern for graduate education in nursing: a 2-year program with a required functional area in the second year, clinical specialization, and the thesis. This was similar to the Yale model. Students chose either a teaching or supervision (administrative) functional area, outside of the nursing specialty area comprised of theory coursework and actual practicum experience under a preceptor's supervision (Foster, 1985a). In addition to the credit hours
necessary to obtain the minor in educational psychology or psychology, nurse-midwifery students were required to take embryology and genetics during the first year.

The emphasis in the nurse-midwifery graduate curriculum was on preparation of nurses to be expert clinicians able to function as teachers, supervisors, consultants or research workers in the field of maternal child health.

The major nurse-midwifery core content areas covered in the program related to antepartum, intrapartum and postpartum care of childbearing women. There was no family planning or well-woman gynecology and very little newborn content offered until the 1970s. The core theory requirements for nurse-midwifery have always been scheduled during the student's first year. Even though this content was presented in different formats with different course titles, the material is essentially the same, updated regularly to meet the changes and advances in maternal-child health care.

Since the 1960s, the nurse midwifery program has included childbirth education and parenting theory courses with a teaching practicum experience, whereby students taught a series of three childbirth education classes: early pregnancy, late pregnancy and early parenting to expectant couples from the community. The faculty have consistently held a strong philosophical commitment to preparation of students in the area of childbearing and early parenting education. In fact, the University of Utah nurse-midwifery faculty developed the Young Mother's Program, a series of childbirth preparation classes for highschool age mothers in the Salt Lake City community (Foster, 1985d).
It is significant to note that whenever a person assumes directorship of an educational program the curriculum will often change. This is also true when new faculty are recruited to a nurse-midwifery program because of the normal tendency to alter existing courses to accommodate their teaching style.

Foster (1985d) recalled six major curriculum changes or coursework rescheduling over the 20 year life span of the program. These are listed in Appendix F in the order Foster stated them with further discussion below.

1. In 1973, the nurse-midwifery graduate program dropped the requirement for a minor in educational psychology or psychology.

2. As clinical sites changed and different ones became available, there were resultant changes in the organization of the curriculum. For example, the pattern of having a major blocked time period in the summer of the first year for clinical intrapartum (delivery) experience was originally developed when the University of Utah's OB/GYN department was the main clinical site. To avoid competition with the medical students for deliveries, nurse-midwifery students obtained their clinical experience during the summer months. This pattern started to change after Shiprock Nurse-Midwifery Service ended their contract to accept students.

Closure of Shiprock, a major clinical site, led to a radical curriculum reorganization in 1980. This curriculum reorganization was necessary to provide classroom instruction in blocks of time during the 1980-1981, 1981-1982 academic years as new clinical sites were developed. The use of "block teaching" received prior approval
from ACNM in 1980 since course content remained constant. However, block teaching was discontinued in March 1982.

Yeomans (1985), director of the program at that time, described the situation which led to "block teaching". The curriculum was adjusted, reducing the time courses were taught, but not limiting content, so that some first year students could go to Hill Air Force Base Hospital (HAFB) for clinical by mid-spring instead of summer quarter.

3. At two or three different times, there have been drastic reductions in credit hours required by the nurse-midwifery program. These reductions were mandated by the University of Utah College of Nursing. Foster (1985d) stated that ironically these reductions in credit hours occurred when there was an increase in course material which needed to be presented, for example, in the mid-1970s when a family planning and gynecology course was added to the curriculum.

In the early years of the program the number of credit hours for required courses in the biological sciences was high. Boehme, a 1974 graduate respondent, admits that the course requirements have been reduced since then.

They had to cut down the course requirements because it was so overwhelming at that time. For example, some courses such as embryology and genetics were required as part of the curriculum, now they are recommended pre-requisites. (Boehme, 1984)

4. Yeomans, Freston, Reeder, and Foster were faculty respondents who participated in the major curriculum revisions in 1976-1977. The nurse-midwifery faculty tended to isolate themselves and their curriculum from the child nursing and perinatal programs. The administrative structural change in 1975-1976 incorporated three
programs, nurse-midwifery, child nursing and perinatal under the umbrella of "Parent-Child" which facilitated the curriculum revisions proposed in 1976-1977.

Yeomans, as newly appointed Director of the Program, was a major facilitator during the 1976-1977 period of curriculum reorganization. Prior to this time, nurse-midwifery courses did not clearly delineate specific topic areas, such as antepartum, intrapartum, postpartum, etc. To design individual courses for specific topic areas required pulling out material from the various nurse-midwifery courses creating a new course, such as antepartum management. The coursework was then presented to students through a more organized consecutively numbered system. This organization also improved the utilization of faculty time and energy (Yeomans, 1985).

Reeder (1985) and Freston (1985) facilitated interaction between these three Parent-Child programs so that integration of child and perinatal nursing students into some of the nurse-midwifery theory courses was possible.

The only difference would be nurse-midwives would have a different clinical experience than perinatal or child students because the nature of responsibilities would be different. But the content would be together. This gave the benefit of dialoging and learning content together, encouraging a Socratic question-answer problem-solving approach rather than a didactic presentation. (Reeder, 1985)

One content area Boehme recalled "as the one thing that everybody said we really needed was more family planning/gyn" (Boehme, 1984). Therefore, the 1976-1977 curriculum revision included designing a separate family planning/gyn course which Freston developed and facilitated (Freston, 1985; Yeomans, 1985).
During this period, the research course, which had been taught separately by each graduate program became part of the core centralized curriculum for all graduate nursing students (Williams, 1985). Incorporation of a stronger research component in the College of Nursing became apparent after Dr. Marie Holley and Dr. John Sullivan came to the University of Utah in 1974 (Freston, 1985). Foster (1985d) and Reeder (1985) stated that many of the curriculum revisions made in 1977 were in response to student request and were based on improved educational principles for learning. Many faculty respondents commented that student evaluations were highly valued and often became a guide to modification of teaching approaches in the classroom and to introduction of new concepts, such as nurse-midwifery practice in alternative birth centers which were just developing at that time (Foster, 1985d; Freston, 1985; Reeder, 1985).

5. In the process of the 1976-1977 curriculum revision, all of the necessary basic nurse-midwifery "skills" which were taught in different courses went into one class, designed and coordinated by Mary Ann Rhodes, CNM faculty. Yeomans (1985) stated:

She did an excellent job. We all got involved in teaching various segments of the skills lab course, because it took an incredible amount of faculty time. But it was important for students to have this skills lab with faculty supervision and worth the effort. (Reeder, 1985)

An additional skills lab included mini-student teaching sessions which were audio/video taped then critiqued with the student and faculty member (Reeder, 1985). During Freston's first year of teaching, she took over this section, organizing and coordinating interviews and tapes to critique with students (Freston, 1985).
6. A major curriculum change occurred when functional areas were dropped as a requirement for all programs within the graduate programs in Nursing. This occurred in the mid-1970s. However, the functional area continued to be strongly recommended during Yeomans' term as Director of the nurse-midwifery program between 1976-1981 (Yeomans, 1985).

Reeder summarizes the importance of offering a functional area in a nurse-midwifery educational program:

The faculty and curriculum emphasized leadership in addition to clinical expertise:

We were told how fifty percent of nurse-midwives, whether they thought they were going to be establishing nurse-midwifery services or educational programs or birth centers, actually fell into those responsible positions. And it was well for us to be prepared and to focus in on leadership skills by choosing the teaching or the supervisory (administrative) functional areas. The functional areas were a main strength of the program. (Reeder, 1985)

All of the graduate respondents who took either the teaching or administrative functional area theory coursework plus practicum stated it was a positive experience and helped prepare them to function more effectively in various roles after they graduated (Boehme, 1984; Graf, 1985; Reeder, 1985; Williams, 1985)

In addition to the functional areas, team-teaching acted as a transitional aid for new graduates who accepted faculty positions. The purpose of team teaching was to match junior faculty with senior members to better utilize faculty time (Foster 1985; Freston, 1985; Reeder, 1985). For example, Freston (1985) recalled that "her first classes were team taught ... then she took over the infant assessment
class as her own responsibility" (after having the team-teaching experience).

Several respondents believe that during the next five years new models of education will be developed (Freston, 1985; Reeder 1985). Reductions in funding may force programs to offer alternatives in their curriculums opening the program to students employed part-time. The University of Utah's nurse-midwifery program has always required full-time study and has always "strongly suggested" that students not be employed during their educational program. Foster (1985b) recalled when students were required to sign a release form stating they would not work while attending school. Nevertheless, part-time study has been proposed since 1977 (University of Utah College of Nursing Nurse-Midwifery Program-ACNM Self Evaluation Report, 1977).

The 1982 nurse-midwifery program's ACNM self-evaluation report states: "An effort to actualize past proposals offering nurse-midwifery education other than full-time study has not begun." Freston (1985) commented that "the trend is toward part-time education for nurse-midwifery." In fact, while Freston was a faculty member at the University of Utah she recalled she "wanted to open the program to part-time students," but without faculty and administrative consensus no move was made to direct the curriculum in that direction.

**Teaching Methods**

Throughout the 20-year history of the nurse-midwifery program many different teaching methods were used by the different faculty members. However, Freston (1985) believed that teaching styles were
dictated by the volume of required course material: "Teaching methodology was pretty well set by the structure of the program. That is, mostly lecture-discussion with required student written and oral presentations."

For the purposes of this study, teaching methods reported most often by respondents in interviews will be presented in numbered categories.

1. During the early years of the program, prior to 1972, physicians, usually obstetricians from the University of Utah's OB/GYN Department, taught classes on technical or medical complications in obstetrics, as well as anatomy and physiology to nurse-midwifery students. For example, during Reeder's first year (1971-1972) the nurse-midwifery students attended anatomy and physiology lectures given at the College of Medicine for medical students. However, the nurse-midwifery faculty definitely were committed to giving a nurse-midwifery perspective for any content related to nurse-midwifery (Boehme, 1984; Reeder, 1985). Most graduate respondents from the early 1970s and Foster (1985d) were in accord in emphasizing that instruction in the classroom was primarily by nurse-midwifery faculty, supplemented by periodic lectures from physicians.

2. A combination of teaching styles or methods was utilized to increase the student's ability to actually practice clinical nurse-midwifery safely and with some degree of confidence before approaching the client in a clinical setting. Foster (1985d) called this "reality orientation" for students. The skills lab, which was organized into a separate course by Mary Ann Rhode, allowed students
to move from one station to the next, receiving supervised instruction in basic nurse-midwifery skills from hand skills for delivery, or episiotomy repair, to performing microanalysis of urine, blood or vaginal smears. Three faculty, Rhode, Boehme and Hames, published an article, "Teaching Aids for Nurse-Midwifery Education," (1979) to share the teaching methods ideas developed at the University of Utah.

Another part of "reality orientation" as a teaching method provided students the opportunity to practice their history taking/interviewing skills through a systematic process of theory and lab exercises prior to their first clinical experience. Foster created and designed this approach as a sequence of observational, class and laboratory activities which included audio or videotaping followed by review and critique. This history and interview unit was taught over a 2-week period as part of the skills course, which was the first nurse-midwifery course in the curriculum and required approximately 8 hours of class and laboratory. Foster describes this approach in more detail in a journal article entitled: "The Initial Prenatal History and Interview: A Transitional Approach for Learners" (Cameron, 1979).

The skills course and the teaching tool for practicing interviewing were deleted from the curriculum in the early 1980s. Nevertheless, a similar method continued to be used, audio-videotaping of student microteaching sessions in preparation to teach childbirth classes to expectant couples. The sessions are critiqued by student peers and a faculty member with immediate feedback, similar to the history and interview teaching process.
3. The case presentation is a method with which all respondents were familiar. The student is required to write a report about the management of clients taken from their experiences in antepartum, intrapartum and postpartum, then present the case to the class and participate in group discussion. Learning was fostered by student participation in case presentations and written reports, with guidance by faculty. The amount and type of guidance often was dependent on the individual faculty member. Reeder (1985) stated that student led seminars of case presentations were a strong feature of the program, because

...as many faculty as possible would attend for dialogue and feedback regarding the case. Of course, the number of faculty in the program dictate whether or not total faculty representation at these seminars is possible due to the large number of responsibilities placed on academic faculty. (Williams, 1985)

Williams, a 1980 graduate, has come to realize that "a lot of what master's education is about is that you learn to teach yourself. The majority of our classes were run by student presentations" (Williams, 1985).

4. The faculty began to develop study guides as part of course syllabi in the 1975-1977 time period. When the faculty decided to develop more study guides or modules, this system was intended, from the outset, to be an adjunct to the primary curricula and teaching methodologies which were designed around classroom activities, such as lectures, laboratories, and case presentations. Prior to this time, students obtained course information primarily through lecture notes and assigned readings. The impetus for this change occurred because faculty found that they could not cover all the necessary
content in class, especially when there was a forced reduction in available credit hours for the degree. The purpose of the study guides or modular units was to facilitate student's knowledge and understanding of basic concepts through preparation outside of the classroom. This allowed faculty to streamline class time, highlighting important items for emphasis during the lecture. According to Foster (1985d) this was a challenge to faculty to determine what was appropriately included in the study guides for independent study and what faculty needed to present in class.

Even though developing and revising the study guide is a time consuming task (Foster, 1985d; Wheeler, 1975), faculty utilized study guides to the students' advantage. However, only a few study guides continue to be utilized and updated by new faculty.

Boehme designed two modular study guides on anatomy and physiology as a faculty member. Boehme commented, "it is important to learn detailed information because it makes the difference between a professional person and a technician" (Boehme, 1984). Reeder (1985) also recommends utilizing modular learning for basic concepts instead of long didactic class hours. As a 1974 graduate respondent, Reeder remembers class presentations being primarily didactic and long. In some instances there were lectures all day (8 a.m. to 5 p.m.). "I felt that was not the most advantageous framework for learning" (Reeder, 1985).

Regardless of the teaching methods utilized, it is an established precept that learning is best facilitated by crediting and respecting students as adults with valued educational and experiential backgrounds (Bevis, 1978). Learning takes place in an
open environment where both faculty and student accept the roles of teacher and learner simultaneously.

One graduate respondent was concerned with what she experienced as disregard of some faculty for students as adult learners (Williams, 1985). One of the premises of adult education is that each individual administrator (Dean, Program Director), faculty and student alike bring many assets to a graduate program. This is even more noticeable with the rigors of a nurse-midwifery graduate program. Everyone is taxed to the limit. This includes not only their knowledge, skills and competence in clinical teaching or administrative responsibilities but also their humanness. Faculty need to remember their commitment to student education allowing for students to openly communicate their evaluations of the program without threat of reprisal. The University of Utah College of Nursing, Nurse-Midwifery Program offers graduating students an opportunity to verbalize their evaluation of the program through an exit interview with the Program Director. Throughout the program follow-up questionnaire surveys were sent to graduates evaluate and review the program in depth.

This study identified themes from respondents reflecting the desirability of decreasing faculty "inbreeding" and increasing faculty knowledge and skills in the teaching-learning process in higher education. The data did not suggest that faculty were lacking as teachers, mentors or role models for students; however, several interviewees suggested that, in general, the faculty need to be well prepared as teachers and facilitators of learning.
Faculty: Recruitment, Responsibilities and Role Modeling

Regarding faculty, Strahn (1985) stated emphatically that the program needs faculty recruited from other programs "to bring new ideas and fresh ways of teaching in the classroom." Most respondents were in agreement. However, respondents generally agreed that faculty recruitment was a challenge for this program from its inception, because at least one faculty position was unfilled at all times. This created a need for graduates to be encouraged to accept faculty positions.

Several graduate/faculty respondents eased the transition from student to faculty by increasing their clinical skills and competence through a two to nine week internship at a busy medical center. Both Freston (1985) and Reeder (1985) did an internship at Cook County Hospital in Chicago before they accepted faculty appointments at the University of Utah's nurse-midwifery program. Transitions of other graduate/faculty respondents included either working as a clinical nurse-midwife before accepting a faculty position (Graf, 1985) or accepting the clinical instructor position concurrent with starting a private, nurse-midwifery practice (Boehme, 1984; Williamson, 1985). Strahn (1985) accepted a faculty position immediately after graduating, without the benefit of an internship, because the program "desperately needed more faculty."

From a student perspective, Williams (1985) recalls the Director of the Program, Yeomans, as being "overworked," with multiple responsibilities: "She was trying to administer the program, teach her share or an equal share, and also do an equal share of the
clinical supervision of students and it was just too much for any one human being" (Williams, 1985).

One of the increasing demands on academic faculty was to pursue doctoral study in order to meet university requirements for promotion and tenure. This was particularly true for graduate faculty who were strongly encouraged by University and College administrators to upgrade their academic qualifications by pursuing advanced degrees.

A report on long range planning from the College of Nursing dated March 1, 1966, p. 5, stated: "We are convinced that it is time to begin building toward a doctoral program. This may take eight, ten or twelve years, depending on a composite set of conditioning factors difficult to predict." This prediction was very accurate. The doctoral (PhD) program in nursing offered by the University of Utah College of Nursing was established in 1977. This program offers research foci in physiological, transcultural, psychosocial, and educational administration and parent-child nursing. Dean Leininger was quoted in the Daily Utah Chronicle, (April 27, 1977), stating: "We now have 20 doctorally prepared faculty, compared to 4 in 1974 to direct the Ph.D. program."

Of the respondents interviewed, three have pursued doctoral study at the University of Utah College of Health (Foster, 1985b; Freston, 1985; Sevcovic, 1985b). Foster was granted a Ph.D. in June of 1981 in health sciences.

Foster (1985d) states that "faculty had trouble doing much role-modeling, because as soon as an experience was available, the student did it, rather than watching the instructor demonstrate first." She related this to a shortage of student clinical
experiences available to meet and document the required number of clinical experiences each student needed to satisfy ACNM certification criteria.

Respondents were inconsistent in comments regarding faculty members as mentors or role models. Many graduate respondents remarked how important a supportive faculty member was in facilitating student progress through a very stressful program to completion. A few commented that without a particular faculty person's encouragement, patience and support they would not have graduated. (Boehme, 1984; L. Evans, 1985; Strahn, 1985).

Many respondents commented about specific characteristics in various faculty members which were seen as positive role-modeling behaviors for students, yet could not identify one single faculty person as their mentor, or "expert," or role model whom they would emulate broadly (G. Evans, 1985a; Freston, 1985; Williamson, 1985).

"It was a very rich, experienced clinical faculty that we had to draw upon with varied experience" (Reeder, 1985). Yeomans had been involved in the education of residents in Chicago where she performed home deliveries. She shared with Foster the perspective of the Yale program. Because of varied background, interest and experience they contributed different perspectives about how to perform the functions of a nurse-midwife. The focus was on learning a way to do "something" first, but then to become aware of the variety of ways to accomplish the same function (Reeder, 1985).

Reeder (1985) commented that the clinical teaching skills of some of the Shiprock faculty were "wonderful." The faculty at Shiprock pushed students to identify their rationale for decision
making and gave immediate feedback; this she saw as role modeling behaviors.

One of the positive characteristics of faculty role models or mentors discussed by some graduate respondents was the ability to be not only sensitive to the student's learning needs but also to be sensitive to the client's needs in the clinical setting. How faculty members offered clients a true family-centered experience through nurse-midwifery skills and knowledge was recognized as positive role modeling for students. This was demonstrated most clearly when faculty supervised students at one or more of the various clinical sites contracted with the University of Utah College of Nursing nurse-midwifery program.

**Clinical Sites**

To a large degree, the quality of any nurse-midwifery educational program depends upon the character of clinical experiences available to students. It is for this reason as well as the ACNM's emphasis on preparing nurse-midwives as clinical specialists that it is important to examine clinical sites utilized by the University of Utah nurse-midwifery program in some depth.

Ten respondents from the study were asked about their perceptions of the strengths and weaknesses of the nurse-midwifery program at the University of Utah. A few volunteered this information without direct questioning. Six of the 10 replied that the clinical experiences they obtained and/or the clinical sites available were a definite strength of the program. Shiprock Service Unit, which was a major clinical site for students from the
University of Utah for 9 years (1971-1980), was mentioned specifically by three of the six students as a strong component of the program.

During the first 6 years of the nurse-midwifery program (1965-1971), the University of Utah Medical Center was the only local clinical site where the full scope of nurse-midwifery practice (antepartum, intrapartum, and postpartum care) could be practiced and learned by nurse-midwife students. Consequently, the University Hospital served as both a beginning and an advanced practicum site for nearly all of the early graduates of the program. It was essentially their only means of obtaining clinical experience.

At the time of the program's development, Foster did not intend to use the University Hospital for students' intrapartum (labor and delivery) experience. She said:

Well, I can't ask to do deliveries here, because I knew they had very few deliveries... I had learned one thing: medical students take precedence everywhere else I've gone. So I thought maybe the Chief of the Obstetrics and Gynecology (OB/GYN) Department at the University Hospital would let us have a caseload of patients that we could follow in prenatal clinic and then send the students out to other clinical sites, as Yale had sent us out, for intrapartum experience. (Foster, 1985a)

Dr. Kaiser, Chief of the OB/GYN Department, supported the graduate education of nurse-midwives during the first 6 years. At their first formal meeting, Foster recalls Dr. Kaiser saying "I want you to know that the entire resources of the obstetrical department will be at your disposal for the teaching of nurse-midwifery students." He said, "I think it is an extremely important thing you are doing." However, before Kaiser made the commitment to work with the nurse-midwifery program, he requested Foster to work as an
Obstetrical Intern, excluding surgery, for the summer of 1965 "to know whether you're worth your salt or not" (Foster, 1985a). After Dr. Kaiser observed Foster's first delivery, which incidentally, was the first delivery in the new University Hospital building, she and the nurse-midwifery program were accepted.

The loss in 1968 of Dr. Kaiser, who was a strong department chief and a very influential physician, threatened instability for the nurse-midwifery program. After his departure the program's future rested, to a large degree, on the position which the new Chief of the OB/GYN Department would take concerning the clinical experience and supervision of nurse-midwifery students (Sevcovic, 1985b). This is true partly because hospitals located in medical centers were regarded first and foremost, as existing to serve the educational needs of medical students and residents (Sevcovic, 1970). Physicians often felt that it was their prerogative to control the educational policies and clinical practice of other health professions, and this was particularly true of nursing. In addition, the leader of any department or program, due to his or her position of administrative power, could set the tone for interdisciplinary relationships (Quinn, 1985; Sevcovic, 1985b).

From 1967 until the summer of 1970, Sevcovic, CNM worked half-time as a faculty member at the College of Nursing and half-time at the University Hospital as a Clinical Specialist on the maternity floor. This position was first conceived of by Dean Quinn and Ms. Minnie Walton, the Director of Nursing Services at the University Hospital. The goals were to improve the quality of nursing care as well as to facilitate experiences for nurse-midwifery
students within the institution (Foster, 1985b). The position was meant to facilitate communication at the nursing administrative level and also to help nurse-midwifery students' integration at the University of Utah Hospital. When Sevcovic was appointed to the position, there were already clinical nurse specialists functioning in medical, surgical and psychiatric units; however, the concept was very new and the role was still evolving (Foster 1985b; Sevcovic, 1985b).

When Sevcovic began to assess the situation for nurse-midwifery students at the University Hospital, she realized that they were "last on the list" for clinical experiences while residents and medical students took precedence. She tried to smooth the way for the nurse-midwifery students by making sure the resident staff in obstetrics knew the capabilities and needs of the nurse-midwifery students (Sevcovic, 1985b). While attending physicians generally supported the nurse-midwifery program, the residents were more variable in their opinions: some were supportive and some were not (Foster 1985b).

The nursing staff at the University Hospital, especially in labor and delivery, also affected the quality of clinical experiences for students and Sevcovic was in a prime position to facilitate interaction between the two nursing groups.

One respondent was a nurse in labor and delivery at the University Hospital from 1972-79. She observed that some nurses enjoyed caring for nurse-midwifery patients and were in alignment with the nurse-midwifery philosophy of care and flexibility in offering patients options for their care. Many other nurses, she
explained, found it very difficult to care for a nurse-midwife patient. She noted that the reluctance of some of the nursing staff to accept nurse-midwives was related to the fact that they (nurse-midwives) were "crossing boundaries" between medicine and nursing:

They were always talking about what they were learning, pointing out contradictory information in the scientific literature, doing things in nontraditional ways, and continually pushing the system to change. (G. Evans, 1985a)

Sevcovic stated that a large part of her job as a clinical specialist and nurse-midwifery educator was to educate health-care providers, consumers, the public, legislators, and others about what a nurse-midwife was. This was certainly true for any clinical site but especially true for the University Hospital. With a continually changing medical and nursing staff the effort to educate others about the role of nurse-midwives was a never-ending process.

In the summer of 1970, Dr. Morton Stanchever became the Chief of the Department of Obstetrics and Gynecology (OB/GYN) at the University Hospital and Foster gradually realized that irreconcilable differences existed between the OB/GYN Department and the College of Nursing nurse-midwifery program. In addition, the census of maternity clients at the University Hospital had begun to drop in 1969 because indigent patients were now eligible for Title IX funds to pay for care by a private physician (University of Utah College of Nursing, 1970). Many of these women sought out private physician care and went to other hospitals for delivery which meant that a higher proportion of University of Utah maternity clients were high risk, and therefore did not qualify for nurse-midwifery management.
With dwindling number of clients, the competition between nurse-midwifery students and medical students and residents for clinical experiences escalated.

The situation was exacerbated when it came to the attention of Dr. Stanchever that many patients who had heard about the nurse-midwifery program came to the University Hospital and requested nurse-midwifery care over physician care (Sevcovic, 1985b). Dr. Stanchever became aware of the increasing numbers of consumer requests for nurse-midwifery care when he began to receive letters from local physicians complaining about the loss of "their" clients to the University of Utah Nurse-Midwifery service. In response to these complaints he wrote a memo to Joyce Foster.

The intensity of the competition became even more apparent when, in late 1971, an article by Associated Press Writer Lynn Olson about the nurse-midwifery program at the University of Utah appeared in several newspapers across the country. The author focused on the advantages of nurse-midwifery care over physician care and, in essence, advertised the nurse-midwifery service at the University of Utah (Olson, 1971).

In March of 1972, Dr. Stanchever sent a five-page letter to Dean Quinn outlining "major things wrong" with the nurse-midwifery program and proposing that changes be made based on his recommendations (Stanchever, 1972). The following problems with the nurse-midwifery program were cited: (1) there were too many students enrolled "for the facilities that are available," (2) nurse-midwives were being trained separately from medical students and residents when they should be trained within the framework of the medical service, (3)
nurse-midwives (who had their own caseload of patients) should not be establishing separate services within health care facilities, because it led to competition between medical and nurse-midwifery services and (4) the nurse-midwifery program should be integrated into the educational programs for medical students and house staff. In essence, Stanchever's proposal was to transfer control of nurse-midwifery education to physicians.

Stanchever proposed a system of education for nurse-midwifery students which would be supervised by the Department of Obstetrics and Gynecology. Nurse-midwives were to be a part of the hierarchical, physician-directed health care team. He insisted that he have direct input as to the numbers of nurse-midwifery students that could be accepted into the program and proposed that Dr. Warenski, a resident on his staff, serve with the nursing school in the selection of students "primarily as a liaison man to prevent unexpected surprises" (Stanchever, 1972).

As a result of several meetings between representatives of the Department of OB/GYN and the College of Nursing, compromises and negotiations were made which ultimately altered the nurse-midwifery program. The major change was that nurse-midwifery students would no longer be permitted to have their own caseload of patients to follow from prenatal care in the clinic, through labor and delivery at the University Hospital, to postpartum follow-up. This was opposed by several nurse-midwifery clients who, once the changes in the nurse-midwifery service were implemented, began to write letters of protest to Dr. Stanchever. The general theme of these letters is (a) a stated objection to the practice of not allowing nurse-midwifery
students to follow a client throughout her maternity care, (b) listing of the reasons why clients prefer to have care given by one consistent nurse-midwife care provider and (c) description of the benefits of nurse-midwifery care as perceived by the consumer (Barlow, 1972; Nelson, 1972).

Another critical change implemented was to put residents in obstetrics in charge of assigning medical and nurse-midwifery students randomly to clients in the prenatal clinic, as well as being "directly responsible for each patient in labor" (Warenski, 1972). This system of care, once initiated, led to a situation in which midwifery students were restricted from the opportunity to develop excellence in nurse-midwifery skills (White, 1972).

Two of the graduate respondents interviewed did an advanced practicum rotation in their second year at the University Hospital with the medical students, rotating through the Obstetrics and Gynecology services in 1972-73. One was a student at the time, Sr. Francelyn Reeder, and the other was a faculty member, Margie Freston. Though they found this to be a valuable experience, both women pointed out the difficulties of working within the institution as nurse-midwives: "There didn't seem to really be a place for nurse-midwives who were looking to do very normal deliveries on very normal people in a teaching hospital when there wasn't very much 'normal' going on" (Freston, 1985). Freston also felt that part of the reason for difficulties between the nurse-midwifery program and the Department of OB/GYN was that relationships were not good at the administrative level. However, she found the relationships between
resident medical students and nurse-midwives to be very good (Freston, 1985).

There were several factors, in addition to a change in administration in the Department of OB/GYN, which led to the eventual withdrawal of nurse-midwifery students and faculty from the University Hospital. Several interviewees stated that the risk level of the maternity client population at the University Hospital was too high for nurse-midwifery management (Boehme, 1984, Foster, 1985b; Freston, 1985; Yeomans, 1985); therefore it was not an optimal clinical site. Even those clients who were in a low risk category were generally treated as potentially high risk and therefore not allowed many options for their care. For example, all women were required to have IVs during labor and delivery and continuous electronic fetal monitoring. This is the antithesis of nurse-midwifery management which emphasizes client participation in decision-making and minimal intervention in low risk labors. In addition, the opportunity for students and faculty to offer clients continuity of care throughout their pregnancy, labor and delivery was considered by faculty to be an essential part of the student experience. This belief in continuity of care was not shared by the new Chief of OB/GYN and therefore he did not support attempts by nurse-midwifery educators and consumers to maintain this experience for students (Foster, 1985b).

During the same time period, in March of 1971, a bill to permit licensure of Certified Nurse-Midwives in Utah was signed into law by Governor Rampton after passage through the Utah Legislature. The nurse-midwifery faculty predicted that the statute would eventually
enable the expansion of nurse-midwifery practices throughout the state and make available additional clinical facilities for the preparation of nurse-midwives (University of Utah College of Nursing, 1971).

In the fall of 1971, the Murray Clinic, a prenatal clinic for low income women which was funded by the Salt Lake City/County Health Department, made one-half day a week available for a nurse-midwifery prenatal clinic to be operated by the University of Utah nurse-midwife faculty and students (University of Utah College of Nursing, 1972). This was facilitated primarily by Carol Milligan, CNM, a 1968 graduate of the University of Utah nurse-midwifery Program and supervisor of Maternal Child Health for the Salt Lake County Murray Clinic. The clinic was staffed on other days of the week by residents and staff from the University of Utah Department of OB/GYN, who agreed to provide physician consultation to the nurse-midwifery service. All clients seen at Murray Clinic were delivered by nurse-midwife students and faculty at the University Hospital until sometime in the mid-1970s when intrapartum nurse-midwifery management no longer was possible (Cameron, 1975).

During negotiations in 1972 between the Department of OB/GYN and the College of Nursing, attempts were made to maintain Murray Clinic as a site where nurse-midwifery students could follow the same client continuously throughout the maternity cycle; however, Stanchever made the decision to have the resident in charge of the clinic responsible for assigning medical students and nurse-midwifery students on a random basis to clients for delivery. This policy was renegotiated
later in the year so that each nurse-midwifery student was permitted to choose two clients "for continuity of care" (Foster, 1985b).

Murray Clinic continued to be a clinical site for nurse-midwifery students to obtain experience in giving prenatal and postpartum care intermittently until 1981 (Yeomans, 1985). Two graduate student informants described it as a busy service—"too busy, in fact" because of the high patient load (Boehme, 1984; Strahn, 1985; Williamson, 1985). The students sometimes took too long to do a prenatal exam and thus slowed down the flow of the clinic. On such occasions, Boehme, who was the clinical supervisor, would take over and finish the visit for them (Strahn, 1985). Nevertheless, Murray Clinic was seen as a positive experience for students.

The nurse-midwifery program was able to survive after withdrawing from the University of Utah Hospital by developing a clinical site in Shiprock, New Mexico for the majority of students' practicum experience. The first group of nurse-midwifery students from the University of Utah went to Shiprock for clinical experience in the summer of 1971.

The key people involved in the development of the Shiprock Project were Dean Emeritus Quinn and Lorraine Sevcovic. The idea to start this service mushroomed when the need to improve health care of an indigent population was recognized by Miriam, an RN friend of Sevcovic's who worked for the United States Public Health Service (USPHS) Indian Health Service (IHS) at Shiprock, New Mexico. Miriam told Sevcovic that "Dr. Royal Goertz was the only obstetrician at
Shiprock and was very overworked. He [would see] a hundred patients at a clinical session...He was always on call" (Sevcovic, 1985b).

Knowing the physician's concern about the quality of care he was able to give because of the lack of qualified personnel and the large number of patients to be seen, this nurse described to him the nurse-midwifery program at the University of Utah and gave him Dean Quinn and Sevcovic's names. Miriam said to Dr. Goertz, "Four hundred miles north of here is a school of nurse-midwifery and they are looking for clinical sites." Goertz contacted Dean Quinn and, in fact called Sevcovic in Salt Lake City to discuss the possibility of starting a nurse-midwifery service at Shiprock (Sevcovic, 1985b).

Sevcovic went to Shiprock in the spring of 1970 and met with Goertz to outline a plan for a nurse-midwifery service. When she returned to Salt Lake City she met with Foster and Dean Quinn to make more detailed plans. Because Dean Quinn's expertise was in public health and community health, she and Sevcovic were the primary initial planners of the Shiprock Maternal and Child Health Service Project. A proposal was filed with the Indian Health Service seeking federal funding.

Dean Quinn, Sevcovic and Foster met with the Navajo Tribal Council on July 7, 1970 to seek approval of the planned project and were asked three questions:

1. Was the University of Utah College of Nursing planning to come for only 1 year and then leave as so many other people had done in the past? The answer was that the proposed project was to last 5 years and that it was hoped enough strength would be built into the project that it would endure beyond the funding period.
2. Was the College planning to study the Navajos? The answer was no. The Tribal Council was invited to study the College's program to see if it had any merit for their people.

3. Would the College's program educate the Navajo people to do what it was proposing to do? The answer to this question was that, yes, the College had built opportunities for the education of the Navajo people into the services it would be providing (Sevcovic, 1973, pp. 53, 54).

One of the objectives of the Maternal and Child Health Service Project at Shiprock was to provide a sound clinical service for women and children that would facilitate quality learning experiences for graduate nursing students, professional and nonprofessional personnel from the Indian Health Service, and other coordinating health agencies. (Sevcovic, 1973, p. 55)

In the first year of operation the nurse-midwifery service was funded jointly by the University of Utah and by the Indian Health Service with federal funds received for maternal and child health care. By the second year of the project, two additional funding proposals were written by the University of Utah College of Nursing for family planning and for child and youth services. The family planning proposal was funded in April 1971 to be administered through the Denver office of the Children's Bureau (DHEW). The Child and Youth Health Service proposal was a grant through the Dallas office of Public Health Service-IHS for provision of ambulatory preventive health care services to children and was funded in June 1971 (Sevcovic, 1973; 1985b).

Shiprock Maternal and Child Health Service Project was more than a nurse-midwifery service. It was a community health service which
focused on preventive health care, early identification of deviations from normal, treatment of illness and injury and rehabilitation (Sevcovic, 1973). Because Shiprock Service Unit served an all-Navajo population it was crucial for the Navajo people to be involved in planning and administering the service. In addition, the Tribal Council had made it clear that the Navajos wished to be educated so that they could eventually provide health care to their own people. Therefore, a system of education for the Navajos was devised so that some could become community health aides through a training course. Nurse-midwives taught nursing classes at the nearby Farmington Community College and at Shiprock for licensed practical nurse students. There were many community education programs presented by the CNMs and others on family planning, family living, adolescent growth and development and childbirth preparation. Upward mobility for Navajos who worked within the project at Shiprock was also incorporated into its structure (Sevcovic, 1985b).

The Navajo people have distinctive cultural beliefs and values about health, pregnancy and childbirth which govern their behavior. Their belief system is quite different from that of the average American. For instance, while American medical care is disease oriented and focused toward crisis intervention, Navajo tradition emphasizes the fact that pregnancy is a blessing, an important event, a subject for congratulations—certainly not a disease (Sevcovic, 1979).

It is important for those providing health care to the Navajo to be cognizant of these beliefs and respect the importance they hold for the people. Many of the Navajos who came to Shiprock for health
care were not English-speaking and this set up an additional barrier, beyond the differences in cultural beliefs about health, to providing adequate health care.

A wide variety of health services were offered at Shiprock Service Unit including prenatal care, family planning, gynecology, postpartum, well-baby checks and immunization clinics. These services were operated and staffed by nurse-midwives, pediatric nurse specialists, public health nurses, and health aides and medical doctors. The 75-bed hospital in Shiprock, which was adjacent to the clinic buildings, provided inpatient and outpatient services for people with a variety of health problems. All deliveries conducted by the nurse-midwifery service CNMs took place in the hospital setting and the women then stayed in the hospital with their newborns for a 1- to 4-day period of recovery. There was an obstetrician on call for consultation or referral who was readily available to the staff. It was estimated that approximately 80-85% of all births at Shiprock Hospital were attended by a CNM (Sevocvic, 1985c).

Student nurse-midwives from the University of Utah had their major clinical experience at Shiprock during the summer of their first academic year starting in 1971. Three to six students were assigned to the service at one time for clinical experience. The students spent from 6 weeks to 3 months at Shiprock working in the various clinics, taking call for deliveries at the hospital, and doing postpartum rounds--providing the full scope of nurse-midwifery services. In the first few years of the project (approximately 1971-1977) the majority of students sent from the University of Utah were at the beginning level of practice and therefore required a
great deal of supervision. From 1977-1980, the majority of students who went to Shiprock were advanced practicum students who already had a fair amount of clinical experience in Salt Lake City and therefore required less intense supervision by Shiprock faculty (Sevcovic, 1985c).

Lorraine Sevcovic acted as the Director/Administrator of the nurse-midwifery educational program and nurse-midwifery service program at Shiprock. She was the on-site coordinator between the Indian Health Service and the College of Nursing from 1970 to 1978. At that time Sevcovic resigned from her position and took a 6-month sabbatical before beginning doctoral studies at the University of Utah. The nurse-midwifery service at Shiprock expanded from an initial staff of three to seven CNMs. There were faculty and staff nurse-midwives at Shiprock, both of whom were responsible for clinical teaching. The faculty CNMs held the master's degrees, while staff nurse-midwives had earned a certificate in nurse-midwifery but no graduate degree. There was also a large corps of auxiliary staff composed of professionals, such as physicians, public health nurses, and pediatric clinical specialists, and para-professionals such as community health aides.

Freston was among the first group of four students from the University of Utah who went to Shiprock in the summer of 1971. She described the difficulties of adjusting to a different culture as well as the stresses of orienting to a new service and being away from her family; however, she stated that learning midwifery at Shiprock was a very good educational experience. She recalled that it was the first time she really felt she was "doing midwifery."
Freston returned to Salt Lake City with a better grasp of what nurse-midwifery was about because she was able, finally, to apply "book learning" to clinical practice (Freston, 1985).

Despite the difficulty of adjusting to a different culture, every graduate respondent who went to Shiprock spoke in very positive terms about the clinical site. Mention was made several times by interviewees of the quality and quantity of clinical experiences available to them at Shiprock within what they generally found to be a supportive environment where students could focus totally on what they felt to be "real midwifery" (Boehme, 1984; Graf, 1985).

Three of the students interviewed who went to Shiprock for clinical experience in the summer between their first and second academic years returned to Shiprock in the fall for an administrative practicum supervised by Sevcovic (Graf, 1985; Reeder, 1985; Williamson, 1985). These students also found the administrative practicum at Shiprock to be a very valuable experience.

Considering the overwhelmingly positive accounts of Shiprock as a clinical site for nurse-midwifery students, it is not surprising that many students were very disappointed when it was no longer available as a clinical site after the summer of 1980 (Sevcovic, 1985c). In the summer of 1978 on orientation day, 11 of the entering class of 12 nurse-midwifery students said that they had come to the University of Utah primarily because they wanted to go to Shiprock. Only 6 of those 12, however, actually went to Shiprock in the summer of 1979 (Williams, 1985), perhaps because problems were already occurring within the administration that eventually led to "mass resignation of the CNM staff at Shiprock" (Yeomans, 1985). In 1980
the rash of resignations ended the involvement of the University of Utah nurse-midwifery program in the Shiprock project but it did not mean discontinuation of nurse-midwifery services to the area Navajos.

The specific reasons for termination of Shiprock Maternal and Child Health Service Project as a clinical site for nurse-midwifery students from the University of Utah are not clear. None of the interviewees was on staff at Shiprock during the period of instability prior to the complete changeover in nurse-midwifery staff. The person who was Director of the Nurse-Midwifery Program at the University during that period declined to explain details of the changes which occurred (Yeomans, 1985). Primary written sources indicate there were problems among the administrative staff. There was also an active move by the IHS, as well as a desire on the part of the Navajos to have more control over the project. These are cited as possible causes for the change in staff and cessation of University involvement in the project (Yeomans, 1980).

Whatever the cause for its dissolution, it is clear that the nurse-midwifery service at Shiprock not only provided students with valuable clinical learning experiences but also significantly improved the quality of health care for the entire Navajo community serviced. This unique service was also the first of its kind to be entirely organized and administered by nurses (Foster, 1985b). Sevcovic, who was Director of the nurse-midwifery service at Shiprock for 8 years, noted the significance of this fact, stating that in order to provide nurse-midwifery students with good clinical experiences an educational program must have the use of a clinical site controlled by nursing. She recognized this as a strength of
Shiprock and the probable reason why it was so successful (Sevcovic, 1985b).

It was fortunate that by the time Shiprock was not longer available to the University of Utah as a clinical site, another very strong nurse-midwifery clinical site had been developed at Hill Air Force Base (HAFB) 33 miles north of Salt Lake City in Layton, Utah. The idea of developing a nurse-midwifery practice at HAFB came about in April 1973 when Foster and Dean Quinn learned that plans were being made to close the obstetrical service at the base hospital due to a shortage of OB/GYN physicians in the military service. Dean Quinn made contact with the Director of Nursing Services at HAFB and proposed that the University of Utah College of Nursing be given permission to utilize the clinical obstetrical facilities at Hill Air Force Base for the education of nurse-midwife students (Quinn, 1973). The nursing service director at HAFB was of the opinion that a nurse-midwifery service would serve to maintain the obstetrical service in operation, as well as services such as pediatrics and gynecology which accompany OB, and ultimately the entire hospital (Foster, 1985b). Because HAFB was a fairly small hospital with a large proportion of its census composed of obstetrical patients, the proposed discontinuation of the OB department might have led to closure of the entire hospital. Negotiations between Dean Quinn, Foster and the Director of Nursing at HAFB eventually led to the establishment of a nurse-midwifery service in the winter of 1972-73 which was operated initially by College of Nursing nurse-midwifery faculty. During the summer of 1974 the first nurse-midwifery students were assigned to HAFB for clinical experience.
HAFB was originally meant to be an optional clinical site for students, but it very quickly became "automatic" that students went there for some portion of their clinical practicum (Quinn, 1985). The full scope of nurse-midwifery was practiced at HAFB and thus was available to the students; however, patient continuity was one important aspect of nurse-midwifery care which could not be retained at HAFB. The distance of the base hospital from Salt Lake City meant that CNMs could not safely take call from home for deliveries 24 hours a day, 7 days a week. Therefore, patients seen by a faculty or student CNM in prenatal clinic could not be assured of being delivered by the same CNM. This was perceived as a detriment by some nurse-midwifery students (Williamson, 1985).

Because of the way students were scheduled to go to HAFB including assignment to the day clinics, being on call for deliveries, and some calls at night for deliveries only, students could be incredibly busy or have enough free time to study or work on other projects. In addition, a student may never have had any previous contact with the patients she or he cared for during labor and delivery. Some students saw this as a weakness of the program (Williamson, 1985) and were frustrated, at times, by the unpredictability of their experiences there (Evans, 1985b) yet, most of the respondents regarded their experience at HAFB as very positive.

In the beginning stages of the establishment of a nurse-midwifery service at HAFB Foster (1985c) noted that there was an obstetrician who "was very reluctant to let nurse-midwives function the way we now function," but his attitude changed after the
obstetrical service moved into a new hospital building. There were no longer the same kinds of restrictions made on nurse-midwifery practice as there had been prior to the move. The nursing staff at HAFB was perceived by Foster to be very supportive of nurse-midwives though there were, at times, minor problems related to inadequate communication between nurse-midwifery and nursing staff. Foster expressed the opinion that Hill was an enjoyable, positive experience for her as a faculty member (Foster, 1985c). Another graduate respondent gave a very positive evaluation of HAFB from her 2 years there as a student and past 4 years as a clinical instructor for nurse-midwife students (Evans, 1985). One student, in her description of Foster, noted that at Hill, Foster was always stretching the regimented routine to include safe alternatives to birthing and "frequently getting in trouble for it" (Strahn, 1985).

This raises the question of how much freedom to practice independently nurse-midwifery faculty and students actually had over the years at Hill. It should be noted that when Dr. Jones became Chief of the Department of OB/GYN in 1979, he instituted a policy that all laboring clients at Hill be continuously monitored electronically and be given a running IV (Strahn, 1985). This policy did not prevent nurse-midwives from practicing but did limit their options for managing clients in labor.

Nevertheless, Hill Air Force Base Hospital became a very important and crucial clinical site at a time when the University of Utah nurse-midwifery program was still struggling to establish appropriate clinical sites. In 1980, when Shiprock was no longer
available to nurse-midwifery students, Hill became the major clinical site for beginning students.

Even though HAFB Hospital offers faculty and students an environment to practice nurse-midwifery with an essentially low-risk client population, the out-of-hospital birth center setting operated by nurse-midwives allows nurse-midwifery students to practice more autonomously without the restrictions hospital policies or protocols can place on nurse-midwifery practice.

In 1982 the first two birth centers in Utah were opened within a few months of each other, both accepting nurse-midwifery students into their practice for clinical experience.

The idea to establish a birth center in Salt Lake City had been proposed repeatedly by several nurses and nurse-midwives almost from the inception of the nurse-midwifery program. Foster and Dean Quinn had discussed building what they called a Maternity Center, which was to be an in-patient and out-patient facility for prenatal, intrapartum and postpartum care, separate from the hospital and operated by nurse-midwives, physicians, and nurses. Foster had formulated plans for the maternity center to the extent that she drew up a preliminary draft of architectural plans for the building. She discussed her ideas with nurse-midwife students, requesting their input, and arranged an institutional "brainstorming session" to discuss ideas and questions relative to the maternity center. Several local physicians, nurses, nurse-midwives and hospital administrators were invited.

Various possible sites or buildings for this proposed maternity center were explored by Foster and Dean Quinn, including a plan to
locate the center in the University Research Park; however, attempts to obtain funding for the proposed center failed and the plan was temporarily abandoned in the early 1970s (Quinn 1985; Foster 1985b).

The late 1970s brought a new surge of interest in establishing a birth center in Salt Lake City on the part of several CNM graduates of the University of Utah who were practicing in the area. Tyrrel Boehme, a 1974 graduate, had developed a small but growing practice through contacts made with clients seen at regular prenatal visits at Murray Clinic where she supervised nurse-midwifery students. Boehme was not allowed by the physician in charge of the clinic to use the facility to see her clients; therefore she was seeing clients for prenatal care in her home and initially delivered them at the University Hospital. Because of frustration on the part of her clients and herself with attempts by the medical resident staff at the Hospital to control the way she practiced, i.e., requiring that every patient have an IV and continuous electronic fetal monitoring throughout labor, she began to look elsewhere for a physician consultant as well as a new institution in which to deliver her clients (Boehme, 1984).

For several months in 1979, Boehme worked with the consultation of an obstetrician in Ogden and delivered clients who desired this alternative at St. Benedict's Hospital in Ogden. The Ogden medical community did not support Boehme working at St. Benedict's; therefore, without official hospital privileges her practice in Ogden ended. During this time she also began exploring the option of establishing a birth center, yet the idea never materialized.
It was during this time period that Boehme decided to discontinue her private practice, accepting a position with the Planned Parenthood Association of Utah. She described feeling "burnt out" after several years of singlehandedly operating a private nurse-midwifery service and fighting many battles to maintain and nurture her practice (Boehme, 1984).

Boehme and another graduate of the University of Utah Nurse-Midwifery Program, Strahn, began talking together in early 1980 about setting up a home birth nurse-midwifery practice together. They approached several obstetricians in the Salt Lake City area requesting that they consider serving as consultants for the proposed home birth service but none was interested, primarily because they believed home birth to be unsafe. The two women also presented their ideas to the local ACNM Chapter at a monthly chapter meeting and met with opposition from several of their colleagues who believed that to start a home birth service would only serve to alienate area physicians whose support they had worked so hard to gain (Strahn, 1985). It was Strahn's belief that the attempt to start a home service probably caused the medical community to look more favorably upon the alternative idea of starting a birth center. This was seen as a positive outcome by Strahn and others.

Mary Ann Graf was a 1976 graduate of the University of Utah nurse-midwifery program who wanted to create a birth center in Salt Lake City. Soon after completing the program, she was contacted by John Short, a medical economist who had recently helped to establish the first outpatient surgical center in Salt Lake City. He was interested in making a birth center his next project. Short had
taken a group of local anesthesiologists on a tour of all the birth centers in the U.S. and decided that nurse-midwives were needed to work in the center in order to ensure success. He met with Graf and explained that his model for a birth center was to provide 24-hour anesthesia coverage so that all laboring women, if they wished, could receive an epidural block type of anesthesia, which blocks all sensation below the waist. Graf, horrified at the idea, explained why this was not a cost-effective means of providing care to laboring women and described her vision of a birth center operated by nurse-midwives in which access to anesthesia would not be necessary. Her arguments were convincing and Graf and Short continued to work together to realize their goal of a nurse-midwife operated birth center (Graf, 1985).

The next step necessary was to present, and have approved, a certificate of need to the Utah Department of Health, Health Facility Division. Prior to this, however, Graf and Short sought out several physicians and secured their agreement to serve as consultants for the birth center once it was in operation. Shortly after the certificate of need was filed with the State Health Department, each of these physicians was approached by the administration of the hospital at which they had privileges and "had their livelihood threatened in some way" (Graf, 1985). Short and Graf therefore decided to withdraw their certificate of need and wait until a more opportune time to reintroduce it arose.

It was not until late in 1981 that circumstances finally led to the filing of a certificate of need for a birth center which was approved without incident or controversy. At approximately the same
time, a certificate of need was to be filed for a birth center in Salt Lake City to be housed in Utah Women's Clinic. Within a few months of obtaining state approval, both the Birth and Family Center and the Utah Women's Birth Center opened their doors in the summer of 1982.

Utah Women's Clinic was staffed by OB/GYN physicians, nurses and auxiliary staff and provided obstetrical, gynecological and abortion services. The administrator of the clinic in 1981 was Sandra Bagley. Sometime in 1979 Ms. Bagley had spoken to Foster about starting a birth center at the clinic but for reasons that are not known, nothing further was done toward this goal (Foster 1985c). During the 1980-81 academic year the second year nurse-midwifery students from the University of Utah met with Ms. Bagley to discuss the need for a birth center in Salt Lake City and suggested that it be located in Utah Women's Clinic (G. Evans, 1985a).

Sevcovic was interested in starting a birth center for several reasons: (a) she believed it would generate income for the University of Utah College of Nursing, (b) it would provide students with experience in a nurse-midwife controlled clinic and (c) it would provide students and faculty with the opportunity to practice with a low risk population in a birth center setting, thereby offering a different management style. Such an environment, it was hoped, would encourage student nurse-midwives to become more self-reliant, rather than depending on instruments and technological aides. Sevcovic also felt that it would be possible to teach students that one cannot take the same risks in a birth center setting that are possible in a hospital (Sevcovic, 1985c).
At the time that the Utah Women's Birth Center was being discussed the midwifery program was suffering from a shortage of clinical sites; therefore, it is not surprising that Sevcovic conceived of the proposed birth center as an ideal clinical site for students. Because the College of Nursing needed, and was interested in developing, additional clinical sites for nurse-midwifery students, a contract was eventually drawn up between the Utah Women's Birth Center and the University of Utah in which the birth center paid the University of Utah a consultation fee for helping to set up the center. This evolved into a collaborative situation in which the University agreed to pay the birth center a lease fee according to the number of hours the University graduate students utilized the space (Sevcovic, 1985c). Since it was established by CNMs who were on the nurse-midwifery faculty at the College of Nursing, Utah Women's Birth Center maintained a contract with the University of Utah to provide clinical experience to nurse-midwifery students.

In 1979 a survey questionnaire was mailed to recent graduates of the nurse-midwifery program. A total of 26 questionnaires was returned from graduates for the years 1976-79. In response to a question about which nurse-midwifery clinical skills/knowledge should receive greater emphasis in the program, several responses indicated a desire on the part of students to learn midwifery outside of the hospital setting. The establishment of these birth centers made this desire a reality for those midwifery students enrolled in the fall of 1982 and years subsequent to that.

In general, the graduates and faculty respondents stated that the clinical sites available to them for intrapartum experience,
though they were all hospital-based until 1982, were a strength of the program. One student (Williams, 1985) mentioned, however, that the constant struggle for clinical sites was a detriment to the program.

During the early years of the nurse-midwifery program, the University Hospital served as both a beginning and an advanced practicum site because there was literally nothing else available. When the Shiprock service opened to the University of Utah students in 1971, it was primarily as a beginning site where students had their first consistent, long-term practice of nurse-midwifery management. Prior to spending the summer at Shiprock between their first and second years of study, however, students had limited practice giving prenatal care and most students may have done only a few deliveries. The acquisition of HAFB Hospital as a clinical site in 1973-74 made it possible for students to learn basic skills there and then do an advanced practicum at Shiprock or elsewhere.

It was not until after CNM licensure became possible in Utah (1971) that graduates of the nurse-midwifery program were able to stay in Utah and practice as nurse-midwives without becoming a member of the nurse-midwifery faculty. Licensure of nurse-midwives, therefore, opened the door to the establishment of a larger number and variety of nurse-midwifery practices in Utah, which ultimately also meant more clinical placement sites for nurse midwifery students. The development of several sites is significant.

The first clinical site to be developed in Utah, outside of Salt Lake City, was initiated in Vernal in 1975. The site was planned primarily by two nurse-midwifery faculty members, Foster and Freston.
and two recent graduates of the nurse-midwifery program, Karin Hangsleben and Lois Hastings. When the nurse-midwifery service was initiated at Uintah County Hospital in Vernal, it was staffed by Hangsleben and Hastings. Students from the University of Utah were then sent to Vernal for advanced practicum during 1975. Strahn and Kate Sutherland did their senior practicum together in Vernal in the fall of 1978 and reported having been "very busy delivering babies." Though the practicum exhausted both students, Strahn felt it was very valuable experience (Strahn, 1985).

It was in 1975 that LaRita Evans, a 1974 graduate of the program, began working with an OB/GYN physician in Provo, Utah. L. Evans did not have a private caseload of clients, but instead assisted Dr. Harlow Smoot in the office giving prenatal, postpartum and family planning care. She did not conduct deliveries though she did manage the labor of clients, because Dr. Smoot "didn't really want me to do any births. He was insecure about me doing births" (L. Evans, 1985). Gradually, L. Evans became the exclusive provider of prenatal care to a small caseload of clients who sought out her services but she continued to be paid a salary by Dr. Smoot who delivered the clients. Evans commented: "As I look back on it I don't see how I managed to get through all of that" (L. Evans, 1985).

Gradually, it became an unsatisfactory situation for L. Evans and she found a way to finance starting her own private practice. In March of 1980, she began seeing her own clients for prenatal care evenings in the office of a local OB/GYN physician. Shortly after she began her practice, another CNM, Mary Ross, who had been practicing at Maternity Center Association in New York City, joined
her practice. At the time of this study, Evans and Ross were averaging 20 births per month in two local hospitals. Theirs is the only maternity care practice in the Provo/Orem area of Utah whose caseload has not declined subsequent to a worsening of the local economy after massive layoffs at a major steel mill. Ross and L. Evans, in association with five local physicians, at the time of the interview, were constructing a new office building on the grounds of Orem Community Hospital which they planned to occupy sometime in June 1985. This building had additional office space available for lease to other care providers (L. Evans, L., 1985). This nurse-midwifery practice in Provo also accepts nurse-midwifery students from the University of Utah for senior (advanced) practicum.

Deborah Williamson, a 1977 graduate of the University of Utah nurse-midwifery program, was the first nurse-midwife to practice in Tooele, Utah. She began her practice in August of 1977 in association with a group of Family Practice physicians. In the spring of 1980, Gail Evans, at the time a first year nurse-midwifery student from the University of Utah, did a practicum in Tooele with Williamson. Evans mentioned the difficulties which Williamson met in her practice as a result of opposition from the hospital, hospital administration and "old guard" physicians, where she had delivery privileges. When G. Evans was there as a student, Williamson had already been in practice for 3 years, yet the hospital was requiring that a physician from the family practice group with whom she worked be present at every delivery (G. Evans, 1985b).

When Williamson and her husband, a physician who was also employed by the Family Practice Group which employed Williamson, left
Tooele in 1981 for Colorado she described feeling very burnt out. She had carried her own separate caseload of clients, requiring that she be on call all the time, for the 4 years that she was in practice. She felt she had no time for herself, partially because she made herself so accessible to her clients that they could, and would, call her at any time of the day or night with questions or concerns. She was no longer as excited about midwifery as she had been. By the end of her fourth year in Tooele, she described feeling apathetic and indifferent about making it to the hospital to provide labor support and deliver one of her clients. Feelings of exhaustion overwhelmed her (Williamson, 1985).

Beginning with the year 1981 the Utah State Department of Health, through its Division of Maternal and Child Health, has been funding an increasing number of maternity services staffed by nurse-midwives in communities similar to Vernal and Tooele. This increase in the utilization of nurse-midwives for the provision of maternity care funded by the State Health Department was facilitated by one of the study respondents, Gail Evans, CNM. Evans is a 1981 graduate of the University of Utah nurse-midwifery program who began working for the Utah State Health Department as a Maternal Health Consultant in the summer of 1981. At that time only one prenatal clinic in the state was funded through this agency--Murray Clinic in Salt Lake City. Evans began applying for grant money and convincing the necessary individuals of the need for more maternity care services, in particular prenatal care, and of the desirability of hiring CNMs to provide this care. Currently, there are nurse-midwives providing care to Utah's maternity clients in Ogden,
Price, and Provo, who are funded through the Utah State Department of Health. There are also plans to develop a nurse-midwifery service in Logan which would be staffed by a graduate of the nurse-midwifery program at the University of Utah and funded through the State Health Department (G. Evans, 1985b).

While nurse-midwifery has grown in Utah, it has also expanded in other western states. This has impacted the nurse-midwifery program in Utah because nurse-midwifery practices in neighboring states have been a source of clinical sites for the advanced practicum experiences of second year students. For instance, Phoenix Memorial Hospital in Phoenix, Arizona has a nurse-midwifery service which was initiated in July 1972 by two graduates of the University of Utah. This service has been an advanced practicum site for several students from the University of Utah over the past 10 years.

Sally Yeomans (1985), a CNM, and former faculty member of the University started a nurse-midwifery service at Lovelace Air Force Base in Albuquerque, New Mexico in 1982 and since 1984 has offered her service as a clinical site for advanced practicum students from Utah. When Strahn (1985) left Salt Lake City to join her classmate Kate Sutherland in a nurse-midwifery practice in Willits, California in 1981, they also offered to serve as preceptors for second year nurse-midwifery students from the University of Utah. The past 3-4 years students have completed advanced practicum or integration experiences in other states as well, including Oregon, Texas, and Colorado.

There was a need to develop other practicum sites for students in addition to "advanced practicum" placements. Therefore, practice
settings to obtain experiences in areas such as family planning and gynecology were sought, as well, to accommodate necessary curriculum changes. These changes resulted in a broadening of the investigation into new and established clinical settings for student placements. Family planning and GYN or well woman health care were not formally added to the nurse-midwifery curriculum until the mid-1970s; therefore, it was not until this time that it was necessary to provide related clinical experiences for students. Cindy Hames was a 1976 CNM graduate of the University of Utah who had been working in Salt Lake City in a small private practice as well as doing some clinical teaching with the nurse-midwifery faculty. She became employed by Planned Parenthood of Utah after graduation and established clinical practice opportunities for nurse-midwifery students there. In 1976 a contract was drawn up between the Planned Parenthood Association of Utah and the University of Utah which gave nurse-midwifery students access to the Planned Parenthood clinics for clinical experiences in providing contraception and well woman gynecologic care. The students were supervised by a CNM preceptor.

One of the students interviewed, Strahn, found her clinical experience at Planned Parenthood with C. Hames exceptionally productive. Strahn felt that her strength both clinically and academically was in family planning largely as a result of superior instruction and clinical supervision by Hames (Strahn, 1985).

Several of the students who graduated prior to the addition of family planning to the nurse-midwifery curriculum commented that the lack of this content and related clinical experience was a weakness of the program (Williamson, 1985). This comment also appeared
frequently on the replies to a 1979 questionnaire sent to former graduates of the University of Utah nurse-midwifery program (University of Utah College of Nursing Graduate Programs, 1979), in addition to comments about the need for additional instruction on gynecology and well woman care. It is assumed, therefore, that addition of a family planning course and clinical practice was regarded as a positive step by students; however, the researchers did not question the four students who had the new content and clinical experiences at any length about their impressions. The association of Planned Parenthood of Utah with the nurse-midwifery program continues at this writing and was mentioned by Yeomans (1985) as a very beneficial association for the program.

As nurse-midwifery classes grew in size from 5 to 12 students it became more of a challenge to find enough clinical sites in which each student could obtain the number and type of clinical experiences required to meet ACNM criteria to take the national certification examination.

Students

The quality of the students entering an educational program in combination with the quality and character of the educational experiences available within the program help to determine how successful graduates will be in their chosen careers. Several of the respondents mentioned that graduates of the University of Utah nurse-midwifery Program have tended to do well (Graf, 1985) and are known to be in very prominent nurse-midwifery positions throughout the United States (Yeomans, 1985). Some graduates are successful and
influential nurse-midwives and spokespersons for maternal-child health care.

This may be a result of the emphasis placed on leadership in the nurse-midwifery program (Reeder, 1985) which influenced students' socialization into leadership roles. In addition, the method used to select enrollees from the pool of applicants was believed by several respondents to have been a strength of the program (Freston, 1985; Reeder, 1985; Yeomans, 1985) which may have influenced outcome. One respondent, Williamson (1985), specifically stated that the students enrolled in the program were a strength of the program because they were "bright and stimulating" with diverse backgrounds.

Criteria for selection of students have changed very little over the 20-year history of the nurse-midwifery program. Prior to September of 1972 admission requirements were:

1. Baccalaureate degree with an upper division major in nursing, including field practice in public health and psychiatric nursing.
2. Graduation from a nationally accredited college of nursing with a cumulative grade point average of "B" (3.0) in undergraduate work.
3. a) Nursing (NLN) Graduate Nurse Examination.
   b) Miller Analogies Test
4. Licensure as a registered nurse in one state.
5. Satisfactory professional references.

Applicants were then required to come to Utah for a personal interview if they met all the admission requirements. (University of Utah College of Nursing, Maternal-Child Nursing Program, Nurse-Midwifery Specialty Pathway, 1968).

In March of 1972 the decision was made by the College of Nursing Graduate Curriculum Committee to substitute the Graduate Record Exam (GRE) for the NLN Graduate Nurse Examination while all other
admission requirements would remain the same (University of Utah College of Nursing Graduate Curriculum Committee, 1972).

These requirements were developed jointly by the University Graduate School and the College of Nursing. All applicants who met the above criteria were then given a score by a designated nurse-midwifery faculty member who utilized a scoring system based on admission criteria plus interview data or, after interviews were no longer conducted, students' responses to three short essay questions and past nursing experience. This number was then used to rank students before making the final decision on admissions.

There were always more qualified applicants to the nurse-midwifery program than there were available positions (Foster, 1985c). From approximately 1971 through 1979 there were an average of 50 to 60 applicants per year (Yeomans, 1985), the majority of whom met all the requirements for entrance to the program. The task of deciding whom to admit was not an easy one.

In November of 1971 at a nurse-midwifery faculty and staff meeting of Shiprock Maternal and Child Health Service Project the recommendation was made that another admission requirement be added to the above cited list; applicants should have at least 1 year of nursing experience in maternity nursing (Shiprock Service Unit Nurse-Midwifery Faculty and staff, 1971). During the years which followed this recommendation the researchers are aware of three students who were admitted without any previous maternity clinical nursing experience. Two of these three were study respondents. It is therefore assumed that this was never made a requirement for admission though it may have been strongly recommended.
Two of the graduate respondents, Williams (1985) class of '77, and Strahn (1985) class of '79, who did not have prior maternity nursing experience described the difficulties they encountered as students, particularly learning intrapartum nursing and nurse-midwifery skills. They indicated that their lack of maternity nursing experience was a major stressor for them.

In the early years of the program every applicant was required to have a personal interview. This requirement was dropped sometime in the early '70s when the national economy worsened and it became evident that many people could not afford to travel long distances for an interview. After this, phone interviews were required of all applicants until the University of Utah made a ruling that prohibited using data from interviews to influence selection of students (Foster, 1985c).

Student graduate respondents gave several reasons for seeking admittance to the University of Utah nurse-midwifery program. These included: (a) a favorable location [6], (b) master's degree was offered rather than just a certificate in nurse-midwifery [5], (c) a public health emphasis [3], (d) good clinical sites, in particular Shiprock [2], and (e) a good reputation [1].

The majority of the nine graduate respondents in this study reported contact, while a nurse, with a nurse-midwife as a primary inspiration to pursue a career in nurse-midwifery. In two instances (Boehme, 1984; G. Evans, 1985a), the individual who served as a role model was from the University of Utah. Two graduate respondents, Williamson (1985) and Freston (1985), had their first exposure to nurse-midwifery when they became acquainted with British-trained
midwives. Two respondents, Williams and G. Evans, met and were inspired by a CNM who taught maternity nursing to undergraduate nursing students. Thus, it seems that exposure to a nurse-midwife role model while a nurse was an important impetus for these graduate respondents to seek out nurse-midwifery education.

The reasons given by graduate respondents for wanting to be a CNM were varied. Four respondents (L. Evans, Graf, Strahn, Williams) mentioned that they sought out a master's education instead of a certificate nurse-midwifery program because they planned to teach maternity nursing or nurse-midwifery to nursing students. They felt the master's degree would strengthen their credentials for a teaching position. Two of the four who intended to teach did so, for a short period of time, in the nurse-midwifery program at the University of Utah after graduation. Three of these four nurse-midwives, however, are currently in private practice. All of them reported discovering, sometime during their nurse-midwifery education, that they really enjoyed and preferred clinical practice and therefore abandoned their plans to pursue a career in nursing education.

Additional reasons given for seeking a nurse-midwifery education were: (a) to be able to practice more autonomously (G. Evans, 1985a), (b) to have a wider knowledge base in order to give a higher quality of maternity care (Boehme, 1984), (c) to better serve third world countries in need of health care services (Reeder, 1985; Williamson, 1985) and (d) to give women an alternative to traditional obstetrics (G. Evans, 1985a).

The personal and professional backgrounds of the nine graduate respondents were as varied as their motivations to enter the
nurse-midwifery profession. The majority (7) were from out-of-state, coming to Utah from as far away as Michigan and North Carolina to attend, and had prior maternity nursing experience. Five were married and four were single (two of these divorced and two never married); four had from one to four children at home which they were caring for while in the program; some worked while attending school and others did not. The graduates interviewed were from classes of either 10 or 12 students and members of the classes of 1972, 1973, 1974, 1976, 1977, 1979, 1980, and 1981.

Graduates from the classes of 1972-1974 were required to participate in an intensive 2-week group process workshop conducted by a psychologist from the University of Utah Department of Educational Psychology immediately prior to beginning the first quarter of nurse-midwifery coursework. The workshop was called a "Sensitivity Session" or "T-group" in the records. According to three of the four who participated in this experience, it facilitated the formation of a mutually supportive, close-knit group of students. Sr. Reeder (1985), class of 1973, felt that this group session was a strength of the program. It was, however, discontinued after a few years.

Those graduate respondents who did not participate in any formal group process nevertheless described obtaining much support and assistance from fellow classmates. They related spending time studying together, learning from one another, forming close friendships with one or more classmates and, in one or two instances, allying themselves to confront the faculty over an issue. Because the majority of students in each class were from out-of-state and,
therefore, did not have extensive support systems while attempting to meet the challenges of a very demanding, stressful, graduate program, the support of colleagues was, doubtless, essential (Foster, 1985b).

Graduate respondents were asked how much input they felt they had on decision-making about the structure and functioning of the program. Some felt that they had a fair amount of input into the day-to-day decisions made (G. Evans, 1985a) and that faculty were tuned in to student needs (Freston, 1985). Others felt that students had very little influence on decisions made about the curriculum but did not consider this to be inappropriate (Graf, 1985; Reeder, 1985). There were also those who felt the program was inflexible (L. Evans, 1985) and that, when students did complain, faculty handled their complaints by explaining why changes suggested by students could not be implemented (Strahn, 1985). One respondent explained that, because she was not very assertive as a student and was generally pleased with her education, she never felt a need to go to the faculty or administration with a request or complaint (Boehme, 1984).

The means by which a student complaint was handled varied from year to year. Strahn, a graduate respondent class of 1979, said that whenever the faculty noted discontent among the students they arranged a place and time to meet with the class for a grievance session. Her class met with faculty a total of three or four times during the academic years 1977 to 1979 to discuss their needs and concerns. Another student, Williams (1985), remembers her entire class taking an issue to the administration of the College of Nursing (she thinks they met with the Dean) for arbitration when they were unable to reach a satisfactory resolution by voicing their concerns.
to nurse-midwifery faculty. She recalls that the issue, after input from the administration, was satisfactorily resolved without any negative repercussions.

The formal method by which students could express their evaluation of the strengths and weaknesses of the program and make recommendations for change was through an exit interview with a nurse-midwifery faculty member (Foster, 1985c; Yeomans, 1985). It is not known when this was initiated but it continues, in 1985, to be implemented with each graduating class. Another means by which student evaluations of the nurse-midwifery program have been sought is through mailed questionnaires sent to former graduates of the program. Data from a 1979 questionnaire survey of graduates from the classes of 1975-1979 were compiled and analyzed by the graduate program at the College of Nursing. It is not known by the researchers, however, if these data were used to implement changes in the nurse-midwifery program.

After graduating from the University of Utah five of the nine graduate respondents accepted teaching positions: four (Boehme, Freston, Reeder, and Strahn) were hired to teach in the nurse-midwifery program at the University of Utah and L. Evans began teaching maternity nursing at Brigham Young University in Provo, Utah. Four of these five were members of the graduating classes of 1972, 1973, and 1974. Three additional graduate respondents have been and/or continue to be part-time clinical faculty at the University of Utah.

It is something of a paradox that a nurse-midwife would accept a teaching position when it is acknowledged that the primary goal of
nurse-midwifery education is to prepare expert clinicians (Foster, 1985c; Reeder, 1985; Sevcovic, 1985). The reason for this paradox lies in the fact that, until the mid-1970s in Utah there were few, if any, clinical practice positions available to nurse-midwives not affiliated with the educational program. It was not until the 1970s that there appeared a national trend toward nurse-midwives setting up group or solo nurse-midwifery private practices (Foster, 1985c; Williamson, 1985). Once this trend became apparent, faculty at the University of Utah began urging their students to set up private practices after graduation (Williamson, 1985). Prior to this time, it was acknowledged by two faculty respondents, Foster and Yeomans, that the private practice of nurse-midwifery was not envisioned by many educators and therefore not urged on students.

Faculty respondents Foster and Sevcovic, each of whom has been a nurse-midwifery faculty member for approximately 20 years at the University of Utah, expressed the concern that today's graduates no longer are willing to take the risks inherent in establishing a private practice. Instead, they note, new graduates wish to join already existing services and avoid fighting the necessary battles to establish their own private practice. They have also noted that recent graduates are motivated more by personal interests (such as a desire to earn a good salary) than by a true commitment to the profession (Foster, 1985c; Sevcovic, 1985c).

The number of students entering the nurse-midwifery program each year increased from four in 1965 to 10-12 in the years from 1970 through 1983 back to four in 1984. The total number of students who
have graduated from the University of Utah Graduate Program in nurse-midwifery in the years 1967-1985 is 170.

Four graduate respondents, from the classes of 1976, 1977 and 1980 took positions upon graduation which were primarily clinical practice positions. Boehme developed a small private practice in Salt Lake, Graf joined a Health Maintenance Organization (HMO) in Salt Lake City, Williamson joined a Family Practice physician group practice in Tooele, Utah, and Williams became administrator and clinician in the Teen Mom Program at the University of Utah Hospital. These nurse-midwives and several other nurse-midwife graduates from the University of Utah were instrumental in setting up private practices throughout the state.

Gail Evans, immediately after graduating in 1981, accepted two positions: as part time clinical faculty within the program and as the Maternal Health Consultant for the Utah Department of Health. G. Evans was instrumental in establishing public programs to provide prenatal care for both rural and urban local health departments in Utah between 1981 and 1985 (Evans, 1985b).

Those CNMs who involved themselves in local political issues relevant to the practice of nurse-midwifery did not do so without great expenditure of effort and energy. Williams states that one nurse-midwife stopped attending local ACNM Chapter meetings for several years because she was "burned out" in earlier years by her involvement with the ACNM Chapter as Chairperson.

Deanne Williams retained the ACNM Utah Chapter chair position for one and one-half terms (3 years) then chaired the Utah ACNM Legislative Committee for 2 years. Williams continues her commitment
Boehme is no longer in full scope nurse-midwifery practice partially because she felt "burnt out" after giving a lot of her time and energy to political issues. She gradually found that she was no longer willing to give that much of herself to the profession. She also came to the realization that, for the effort and time given by nurse-midwives to providing quality patient care, there is very little financial reward obtainable (Boehme, 1984).

Another University of Utah graduate, Williamson, who went into private practice immediately after graduation in 1977 said that by 1981 she was feeling overwhelmed by the nurse-midwifery practice. She described feelings of isolation and burnout that tempted her to seek employment as a nurse-midwifery educator rather than continue her pioneering private practice in Tooele, Utah (Williamson, 1985).

Even though a few graduate nurse-midwives experienced symptoms of burn-out after dealing with the struggles of private practice, at the time of their interview all respondents were actively practicing midwifery in some capacity; clinical practice, education, or administration.

A majority of the graduates interviewed expressed the belief that their educational program prepared them well to meet the challenges of nurse-midwifery practice no matter what their chosen area; clinical practice, administration consultation or teaching (G. Evans, 1985b; Freston, 1985; Graf, 1985; Williams, 1985).

Freston, Strahn, Reeder, and Williams, stated that, since graduating, they had the opportunity to compare their experiences at
the University of Utah with other nurse-midwifery educational programs in the U. S. and came to the conclusion that their educational experiences were superior to those offered in other educational institutions. Strahn felt that students at the University of Utah had closer supervision by faculty than nurse-midwifery students in other programs. Freston noted that, though she was critical as a student, subsequent comparison with other programs has shown her that the clinical experiences at the University of Utah were superior to those offered at many other schools in the country. Williams stated that the University of Utah nurse-midwifery program prepares graduates to function autonomously in a variety of settings and to understand the nuances and skills of true nurse-midwifery practice. An example which she gave of the superiority of the Utah program was the fact that nurse-midwife students at the University of Utah are taught by nurse-midwives, whereas some other nurse-midwifery programs in the United States continue to utilize physicians as instructors.

Sevcovic, Freston, Reeder, Yeomans and Foster stated that they feel student nurse-midwives have, over the past 15-20 years, become more assertive. Freston believes this has resulted in students coming to graduate school better prepared and with higher expectations of their educational program. She believes that students at the University of Utah were encouraged by their nurse-midwifery instructors to be independent thinkers. Several student respondents were also of the opinion that nurse-midwife students tend to be assertive individuals (Graf, 1985; Williams,
1985), and as they progressed through the program they became more assertive (Strahn, 1985).

Legislation Affecting Nurse-Midwifery Practice

Thus far the researchers have recorded and discussed data from respondents' interviews to delve into their past involvement with nurse-midwifery education at the University of Utah. The researchers attempted to discuss similar topics with each respondent that affected the success of the nurse-midwifery program. These topics included information regarding the curriculum, faculty--(teaching methods, recruitment, responsibilities and role playing), clinical sites and students: all issues are intrinsic to the educational program. One major area peripheral to the actual functioning of the nurse-midwifery program yet vital to the program's success was the issue of state legislation enacted to promote nurse-midwifery practice in Utah.

It would not have been possible for a CNM to practice in Utah, other than in conjunction with the nurse-midwifery educational program, without favorable state legislation. Utah legislation which enabled nurse-midwifery practices to be established and to grow also had a major impact on the continuation and development of the nurse-midwifery program at the University of Utah. In addition, the primary facilitators of this legislation were faculty and former students of the graduate program in nurse-midwifery.

During the first 6 years of the program's existence there were no means by which CNMs in the state of Utah could be licensed to practice nurse-midwifery. When the program was initiated Foster,
then Director of the nurse-midwifery program, had investigated ways in which nurse-midwives might be licensed under an already existing law. She discovered a law promulgated in the 1950s under which chiropractors and naturopaths could be licensed to practice obstetrics and wrote a paper documenting a rationale for licensing nurse-midwives under this same law. She sent the paper to the Department of Business Regulation in Salt Lake City. The Director of that department, Floy McGinn, advised Foster and Dean Quinn that he did not think it would be necessary to license nurse-midwives as long as they only functioned at the University Hospital. This explanation was accepted because at the time there were very few states in which CNMs were licensed (therefore Utah would not be an exception) and because there was no intention, then, of practicing nurse-midwifery anywhere other than the University Hospital. Foster was also advised that to push for nurse-midwifery licensure would be politically controversial and therefore ought to be avoided (Foster, 1985b).

It eventually became evident to Foster and Dean Quinn, as well as others, that without state licensure of nurse-midwives new graduates could not stay in Salt Lake City and practice their profession after graduation. This meant no new nurse-midwifery practices were being established in the state. In 1969, in an attempt to remedy this situation, Foster wrote a letter to the Attorney General of Utah asking how nurse-midwives might be able to "regularize" the status of nurse-midwifery in the state. She never received a reply from him (Foster, 1985e).

In August of 1970, Foster stumbled across a very brief article in the Salt Lake Tribune which prompted her to go back to Floy McGinn
for advice. In the article was an opinion from the Assistant Attorney General, Ronald Greenhalgh, stating that nurse-midwives ought to be able to be licensed under an old obstetrics/midwifery licensing law originally promulgated in 1921 (Salt Lake Tribune, 1970). Floy McGinn's response to Foster's inquiry about the feasibility of licensing nurse-midwives under this old law was that he felt it was timely "to try to promulgate your own nurse-midwifery act" (Foster, 1985b). He told her and Dean Quinn that some physicians in Utah had introduced a bill in the current legislative session to license physician's assistants (PAs) and for this reason would probably be very reluctant to oppose a nurse-midwifery licensing bill. He felt that any argument that physicians might make for opposing nurse-midwifery licensure could also be used against the licensure of PAs. He also was of the opinion that physicians would probably be the primary opposers of nurse-midwifery licensure (Foster, 1985b).

Dean Quinn and Foster thanked Mr. McGinn and immediately sought the advice of Utah Nurses Association (UNA) Executive Director, Corallene McKean. Initially, Ms. McKean was opposed to their plan to license nurse-midwives because she was concerned that it would open up the nurse practice act to new interpretation and scrutiny. She quickly changed her mind, however, and told Dean Quinn that if the nurse-midwifery licensing bill was written as a separate bill having nothing to do with nursing but requiring that CNMs be licensed as RNs before applying for nurse-midwifery licensure, she would support it (Foster, 1985b).
The conversation with Ms. McKean took place on a Thursday afternoon. On the following Saturday Foster and Dean Quinn met with Ms. McKean and UNA attorney Irene Warr to review a first draft of a new nurse-midwifery licensing bill written by Foster. The bill stated that the requirements for nurse-midwifery licensure in Utah would be (a) current licensure as an RN in Utah, (b) evidence of having passed the ACNM national certification examination and (c) the applicant must practice according to the functions, standards and qualifications of the ACNM. Ms. Warr added a short statement which said that the CNM applicant would not have to pay an additional fee, other than that required to obtain RN licensure, and then said that she thought Senator Bullen from Logan would probably agree to sponsor the bill (Foster, 1985b).

While Foster was of the opinion that the way to get the bill to pass would be to start disseminating information about it by active lobbying and public meetings, Ms. Warr advised her that the best strategy should be to refrain from all lobbying activities. She felt that if it were kept quiet, the bill would "slide through" the state legislature without much comment or controversy.

The bill came up for a vote on the evening of the last day of the legislative session and Foster was summoned by Senator Bullen to come to the state capitol. She arrived in time to observe the presentation of the bill. At first, she related, no one voted and then somebody got up and said, 'A vote for this bill is the same as a vote for motherhood and apple pie.' Immediately, everybody started to vote and the bill passed by a large majority. It then went to the
House of Representatives where it also passed and was eventually signed into law by the governor of Utah (Foster, 1985b).

The formal licensure of nurse-midwives in Utah made it possible for CNMs to set up practices all over the state rather than being confined to the University Hospital and its affiliate Murray Prenatal Clinic.

The Nurse-Midwifery Licensure Act served nurse-midwives in Utah well until 1979 when the Utah Certified Nurse-Midwife Practice Act was promulgated to amend requirements for licensure, designate specific standards for nurse-midwifery practice, and appoint a committee of certified nurse-midwives within the Department of Business Regulation responsible for setting standards for nurse-midwifery practice, and establish a mechanism for peer review. This practice act made it possible to obtain a ruling by the State Insurance Commissioner making it illegal for insurance companies to discriminate against nurse-midwife care providers.

Tyrrel Boehme, CNM, initiated hearings before the Utah State Insurance Commissioner in August of 1978 in order to:

...determine if the scope of practice of certified nurse-midwives, performing within the standards set by the American College of Nurse-Midwives, constitute similar services to those provided by Doctors of Medicine engaged in the management and care of the essentially healthy woman and newborn in the childbearing processes and whether, therefore, Petitioner and others similarly situated are protected in their rights of practice by Section 31-27-24 of the Utah Insurance Code in the areas of independent practice, independent billing, and independent payment...(Boehme, 1978)

Ms. Boehme, a 1974 graduate of the University of Utah nurse-midwifery program, was in private practice at the time she initiated these hearings. Because third-party payors would not
directly reimburse her for services she provided to clients she was billing insurance companies, indirectly, through physicians at the University Hospital. However, she was unhappy with this system, because "they always made me feel obliging" and she felt dependent on these physicians to obtain money for her. Boehme began to realize that whoever held the purse strings, i.e., the physicians and insurance companies, also held the key to independent practice. It was evident to her that nurse-midwives needed to have control over billing and collection of fees for their services (Boehme, 1984).

Boehme met an attorney interested in assisting her, Lester Ezrati, who was the husband of a nurse-midwifery student, Janet Ezrati. It was decided to appeal for a ruling in favor of third-party reimbursement for nurse-midwives. Initially, Mr. Ezrati was the only one who supported her in her endeavor. The other nurse-midwives in the area "thought I was a little crazy" primarily because they did not think the attempt could ever be successful. Once the hearings were initiated, then the other nurse-midwives in Salt Lake City were "very supportive" (Boehme, 1984).

The hearings were open to the public and were attended by employees of Blue Cross and Blue Shield as well as other local insurance agencies. Boehme remembers being very nervous as she gave testimony about the comparison between maternity care given by nurse-midwives and that given by obstetricians. She recalls that the insurance companies, primarily Blue Cross and Blue Shield, were concerned that nurse-midwifery care constituted a duplication of services and therefore would only increase the number of claims made for maternity care which would then increase health care costs. The
insurance companies claimed that nurse-midwifery care was really medical care and Boehme and her supporters agreed that it did constitute services which were similar to, but not the same as, that provided by doctors of medicine. For this reason, they argued, CNMs should be reimbursed for their services (Boehme, 1984).

The Utah Insurance Code (U.C.A. 31-27-24) stated that: "No insurer shall make...any unfair discrimination...between duly licensed professional groups who are authorized to render similar services..." The Insurance Commissioner therefore ruled that:

All insurance companies subject to the jurisdiction of the Department of Insurance shall henceforth adopt, regard as valid, and consider all claims submitted for maternity care performed by duly licensed Certified Nurse-Midwives in Utah within the scope of their license on the same basis and in an equivalent manner as those claims received for care rendered by physicians. (Day, 1979)

This ruling was not made, however, until April of 1979 because the Insurance Commissioner was waiting to see what, if any, changes would be made in the Nurse-Midwifery Licensing Act of 1971 during the 1979 legislative session. The Nurse-Midwifery Licensing Act was up for sunset review by the state legislature and the Insurance Commissioner felt that it did not clearly outline nurse-midwives as providers on their own right (Foster, 1985b). Once the Certified Nurse-Midwifery Practice Act was promulgated in March of 1979 to replace the 1971 Nurse-midwifery Licensing Act, the Utah Insurance Commissioner was willing to make a ruling on third-party reimbursement to nurse-midwives. The new act more clearly stated the ways in which a nurse-midwife could legally function in Utah and therefore lent support to the arguments presented by Boehme and
others on behalf of direct reimbursement to CNMs by insurance companies.

Boehme and Foster believed that having a separate Nurse Midwifery Practice Act allowed third-party reimbursement for CNMs to happen. Not only did the Insurance Commissioner rule in favor of third-party reimbursement to CNMs, he also ordered that:

...an insurance company [may not] require a Certified Nurse-Midwife [to] be under the supervision, direct or indirect, of an obstetrician or other physician to be eligible for payment. (Day, 1979)

This statement as well as the Nurse-Midwifery Practice Act reinforced the concept that CNMs are health care providers in their own right rather than adjuncts to physician care. These two changes in Utah legislation gave an increased measure of professional autonomy to nurse-midwives in Utah (Williams, 1985).

At this writing the autonomy of nurse-midwives may, again, be in jeopardy as a bill (Senate Bill 70) was introduced to the 1985 State legislature, primarily with the backing of insurance companies, to repeal the antidiscrimination clause from the Utah Insurance Code. This clause is the one which Boehme and Ezrati used to argue in favor of third-party reimbursement for nurse-midwives in 1979 (U.C.A. 31-27-24). The proposed Senate Bill 70 was given a positive recommendation out of committee, but when it was introduced to the State Senate it was tabled. The technical reason for the tabling was related to a total examination and possible revision of the Insurance Code being undertaken by the State Legislature (Williams, 1985).

When the recodification of the Utah Insurance Code was complete it retained the antidiscrimination clause. This clause is one of the
legislative threats requiring vigilance. It was the opinion of Williams (Chairperson of the local ACNM Chapter legislative committee during the 1985 Utah State legislative session) that it would be more difficult to introduce an amendment to repeal the antidiscrimination clause after the recodification than to simply leave the clause out when the code was rewritten. Williams believes that the local CNMs will need to lobby very hard to have the antidiscrimination clause remain in the Utah Insurance Code. Following that, however, Utah nurse-midwives also will need to make sure that the insurance companies are not successful in passing a bill to repeal the antidiscrimination clause (Williams, 1985).

The Salt Lake City ACNM Chapter has been described as a very active group of nurse-midwives; one of the more active and vocal groups in existence (Reeder, 1985; Strahn, 1985; Williams, 1985). Students have been encouraged to join the chapter (Reeder, 1985) and have made significant contributions by becoming very active in state legislative issues which affect nurse-midwifery practice (Yeomans, 1985). During the years 1980-83 chapter members lobbied in favor of passage of the Prescriptive Practice Act sponsored by nurse-practitioners and against state licensure of lay midwives (G. Evans, Williams). The chapter members were also involved in the birth center licensure issue. All of these issues directly affect CNM practice and were eventually decided in the state legislature or by the state health department in favor of nurse-midwives.

Late in 1981 the Utah Department of Health, Health Facilities Regulation, approved adoption of rules and regulations for birthing centers which became law in January of 1982. The rules and
regulations were developed after certificates of need were approved by the department for two birth centers in Salt Lake City as mentioned earlier in this study.

The development of public and private nurse-midwifery practices which were facilitated by the above mentioned changes in state legislation impacted on two major areas:

1. Nurse-midwifery students had more options for alternative birthing in birth center clinical settings within a short drive from campus.

2. Nurse-midwives (graduates and faculty of the University of Utah program) were the first in Utah to offer consumers the option of a birth center delivery as opposed to a hospital or home delivery. The development of these birth centers not only offers the consumer an option but has forced area hospitals to compete in the health care market place to give more family-centered, consumer-oriented care than they have traditionally made available. Over the past 5 years several Salt Lake hospitals have opened "Women's Centers" with newly decorated birthing rooms to compete with the birth centers and each other. It is clear that the nurse-midwifery program, through its faculty and graduates have made an impact in the State of Utah on obstetrical practice and, more importantly, on the health care of childbearing families.

The impact which birth centers have had on obstetrical practices in Utah was described by Graf (1985) when she stated that, in the first year after the birth centers opened 18 or 19 new birth rooms or LDRs (labor-delivery-recovery rooms) were opened in Salt Lake City area hospitals and short stay utilization increased by 421%. Graf
believes that birth centers have done more than anything else to change the way health care is given to mothers and babies in the state (Graf, 1985).
Attempts were made by two researchers to understand relationships and connections between and among historical events and people that contribute to an understanding of nurse-midwifery today. Through these connections the researchers' intent was to shed light on recurrent themes and issues in nurse-midwifery education, so that suggestions or options could be offered for future education and practice. The focus of the study was the historical development of the graduate program in nurse-midwifery at the University of Utah, College of Nursing over the 20-year period of its existence (1965-1985).

Many historical forces are described in the preceding chapters. Analysis of these forces as they have interfaced with the vicissitudes of program development results in an in-depth appreciation of the many struggles nurse-midwifery educators and students have dealt with, and continue to deal with, in order to advance professional nurse-midwifery.

These factors impact on the success and continuation of a graduate level nurse-midwifery program. One cannot describe or evaluate a program by looking at factors in isolation, because the product, the graduate nurse-midwife, is a cumulative result of many interrelated factors. Intrinsic to the program's success are issues
involving funding, curriculum revisions, faculty, clinical sites, students and professional practice issues such as state legislation. The interviews focused on these issues within the context of early American midwives, nurse-midwives' struggles to overcome obstacles from the medical profession and from their nursing peers.

One of the most significant forces behind the initial development and continuation of the program was available funding. In fact, the impetus for the program's development came in the form of available grant funds and interest on the part of the Children's Bureau in Washington, a forward looking Dean, Mildred Quinn, and a Certified Nurse-Midwife with a vision, Joyce Cameron Foster. Over the past 20 years federal funds have supported the program under sequential project numbers. Even though the University of Utah faculty wrote funding proposals for the Shiprock Project, the funds went directly to the project rather than to the University of Utah nurse-midwifery program.

Various funding sources/agencies are needed to cover the costs intrinsic to nurse-midwifery education: faculty, materials, research, student stipends/grants and costs of clinical site contracts. Without funding sources educational programs such as this could not survive. In fact a decrease in federal funding for institutions of higher learning has become a progressively universal problem for most programs, and has recently contributed to a decrease in the number of applicants. According to Yeomans, funding dropped off very sharply in 1980. This has caused problems in universities all across the country, not only in Utah. Programs continue to close because they cannot be funded (Yeomans, 1985). In 1985 two nurse-midwifery
programs closed, the University of Mississippi and the University of Arizona. The trend of decreased funding for nurse-midwifery programs must be reversed before more programs are forced to close.

Innovative ways to obtain new funding sources both federal, state, and private sources need to be constantly evaluated by the Dean of the College of Nursing and the Director of the Nurse-Midwifery Program.

There have been and continue to be many influences brought to bear on the University of Utah College of Nursing, Nurse-Midwifery Program which affect the faculty and students, oftentimes creating a great deal of pressure and stress for all concerned.

Nurse-midwifery is a practice profession; therefore, its educational programs must be able to offer clinical experiences to students which meet the ACNM core competency criteria, in order for the profession to survive and prosper. The ACNM Education Committee developed the "Core Competencies in Nurse-Midwifery; Expected Outcomes of Nurse-Midwifery Education" in February 1978 (ACNM, 1979). This document states the fundamental knowledge, skills and behaviors expected of a new graduate, experienced through a standardized core curriculum with specific types of clinical experiences completed before graduation. The nurse-midwifery program at the University of Utah survived and grew, and one of its strengths, as noted by several former students, was the clinical experiences it offered.

It is important, for every nurse-midwifery educational program to have more than one clinical site and to be continually looking for more to ensure diversity and continued availability of student experiences at different types of nurse-midwifery services. The
University of Utah program flourished because it was able to offer antepartum, intrapartum and postpartum clinical experiences in public health departments, free-standing birth centers and in hospitals. Constantly seeking new clinical site options requires tenacity and commitment on the part of faculty to maintain the program. In addition, faculty must be willing and able to be on call during the night and day, to supervise students in labor and delivery management.

For this reason nurse-midwifery graduate education is unique compared to other graduate nursing programs. For example, both students and faculty must be on-call for deliveries or scheduled for 12-hour shifts at agencies such as HAFB Hospital for deliveries. This is stressful, especially when classes are held the next day after being awake all night. In addition since Shiprock no longer was available to students as a clinical site after 1981, faculty needed to locate and coordinate nurse-midwifery services to contract with the University of Utah so that students could be sent to services for advanced practicums during their second year. Students, as well as faculty, were affected by this because many advanced practicum services were and still are out of state requiring the student to move there for 6-8 weeks during the winter or spring quarter of their second year. This increased student stress, compounded by the intensity and nature of the practicums plus separation from support sources of family and friends (G. Evans, 1985). Students also needed to be flexible and resilient to maintain their clinical schedules and attend classes.
In discussing the context of nurse-midwifery in the 1980s, Rooks (1983) recognized that in retaining nursing as its base, problems within the nursing profession will affect the future of nurse-midwifery. Rooks believes that the basic problem within the nursing profession is

that many nursing leaders do not understand that clinical competence--the ability to provide an essential service very well--is the only real basis for security and respect in the health care field. Instead, they have thought that higher educational degrees would ensure nursing of better professional status. (p. 5)

The faculty and student respondents for this study emphasized that proficiency in clinical practice has been the strongest component of the University of Utah's nurse-midwifery curriculum from its inception.

With the development of the parent-child program in the mid-70s, incorporating the nurse-midwifery tract, coursework requirements for the graduate school of nursing expanded. This study's findings agree with those of Raisler (1987) that:

most [nurse-midwifery] programs offer much more in-depth content in such areas as gynecology, community health, ethics, risk management, infertility, and well-child care than was found in the curriculum ten years ago. (p.1)

In addition to expanding nurse-midwifery content in family planning, gynecology, and well-child care graduate nursing students were encouraged to enroll in functional areas such as teaching or administration. This additional preparation is extremely useful for a graduate nursing program educating leaders in the field of maternal-child health; however, requiring a functional area became an obvious overload for many students.
The need to prepare educators and administrators is an important motivation for maintaining the functional areas of teaching and administration in the graduate nurse-midwifery curriculum. Since these functional areas are no longer required at the University of Utah fewer students have taken these courses and practicums. Factors prohibiting nurse-midwifery students from enrolling in teaching or administration courses are time, energy and money. Even though the number of required credit hours has been reduced over the 20-year evolution of the curriculum, the combination of credit hours which were not reflective of increased course content along with many clinical hours frequently causes burn-out in the student. Without strong encouragement to take elective courses, students will choose not to do so (Yeomans, 1985).

The high number of credit hours is interrelated with a lack of flexibility in the curriculum to allow for courses other than those required either by the graduate program or the midwifery curriculum. Of course, students who elect to obtain more knowledge in the areas of teaching, administration or research, continue to enroll in these courses, regardless of the increased work load. Because of students' clinical schedules, elective graduate courses are difficult to add to an already busy schedule. In addition many students currently work part-time to support themselves during their graduate study, because of the decreased stipend/grant monies available.

Changing the curriculum to offer part-time study would be beneficial for some students who would otherwise not be able to attend graduate school. If part-time study is offered it will take longer for students to complete their degree, possibly causing a
decrease in the annual number of nurse-midwives graduating and entering the workforce. Yet, if part-time study was available, students could enroll in elective courses at their own pace, decreasing the stress of completing graduate work within a prescribed period of time.

Curriculum revision within the University of Utah's nurse-midwifery program often reflected changes in clinical sites and/or the number of faculty retained during any one year. It is evident that some of the curriculum revisions such as "block teaching" were not ideal, but were necessary at that time for the nurse-midwifery program to survive. Even when sudden major changes were necessary, the program was able to continue because of the dedication and commitment of faculty and program directors to create new clinical sites and revise curriculum to accommodate the availability of those sites.

This was not easy to accomplish in view of the amount of course content that was required of students before they started clinical experiences with clients. Faculty demonstrated flexibility by adjusting the curriculum and content areas in order to prepare students for clinical experiences.

The caliber of the faculty is of paramount importance. The individual faculty member's personal and professional commitment to excellence in nurse-midwifery graduate education directly affects the success of the program. The faculty and program director's ability to solve difficult scheduling and funding problems under pressure from the College of Nursing and the ACNM accreditation requirements for graduate nurse-midwifery study allowed the program to thrive.
Yet, sometimes drastic curriculum changes were necessary and student enrollments were decreased because of a lack of an adequate number of faculty members and/or clinical sites for instructing students in a supportive safe learning environment. The faculty at the University of Utah College of Nursing have always had responsibilities for both academic and clinical supervision of students, with the exception of part-time clinical instructors or preceptors.

Over the years demands have multiplied on academic faculty to meet tenure requirements and to initiate faculty clinical practice to maintain skills. The director of the nurse-midwifery program often carried the greatest burden, juggling administrative tasks in addition to teaching, research and clinical supervision. All faculty have been required to attend regular curriculum committee meetings and summer retreats to revise and update the curriculum and to discuss issues and/or concerns. The National League of Nursing describes the faculty dilemma.

The 1980s will see the climax in expectations of scholarship on the part of the nurse educator. More stringent criteria for academic preparation and subsequent scholarly achievement have gradually been required of faculty in schools and departments of nursing. Research and publication are now of the essence for tenure and promotion; more and more they are criteria for appointment. Interestingly enough, the demand for scholarly productivity is coming at a time when budgets are tight, the number of positions is shrinking, and teaching demands are increasing. (Infante, 1985, p. 19)

There is a trend for nurse-midwife faculty to initiate clinical practices so that they are able to maintain and teach a philosophy of low risk noninterventionist obstetrical and gynecological care. This would give nurse-midwifery students ideal clinical experience sites and facilitate autonomy of the profession through nurse-midwifery
control of the educational environment. Many graduates now direct nurse-midwifery services which are affiliated with the University of Utah nurse-midwifery educational program for second year advanced practicum students. These graduates have shown a continued commitment to the University of Utah Nurse-Midwifery Program by actively participating in students' education, offering students experience in their services.

The turning point in both nurse-midwifery practice and education in Utah occurred in the 1970s with the development of a specific Nurse-midwifery Practice Act, licensing nurse-midwives to practice in the State of Utah. Once nurse-midwives were licensed under a separate act, regulating their own practice, the Utah Insurance Commission granted nurse-midwives eligibility for third party reimbursement. Both of these events become possible because of graduates and faculty of this program who struggled with legislative and medical resistance to their cause and lobbied for consumer support. Their determination was instrumental in opening Utah to nurse-midwifery practices, both private and public.

It required very strong-willed, assertive and determined nurse-midwives to set up and maintain private nurse-midwifery practices during the late 1970s when it was not accepted or encouraged by physicians or by peers. Graduate respondents reported that it was not until approximately 1975 when they were first encouraged by faculty to consider setting up their own practices. The establishment of private nurse-midwifery practices throughout the state of Utah began around 1975 and mirrored national nurse-midwifery trends in this direction. Now that the pioneering efforts of others
have paved the way for graduates of the 1980s to continue to establish private practices throughout the nation, there is concern that this avenue will no longer be pursued by recent graduates, because of personal reasons and prohibitive liability insurance costs.

To be able to set up a successful private nurse-midwifery practice the nurse-midwife needs information regarding how to set up and administer a practice. Therefore, in addition to preparing expert clinical practitioners, nurse-midwifery education should guide and direct nurse-midwives to meet the challenge of various roles such as teacher, counselor, administrator, researcher or consultant.

Reeder (1985) articulated what most respondents consider as a major focus today in nurse-midwifery education: "to equip [nurse-midwives] in the political, legal and ethical questions dealing with our practice." Nurse-midwives have to be equipped very soundly with the knowledge and skills of political know-how (Reeder, 1985), in order to deal with legal issues arising in every state regarding licensure, obtaining third party reimbursement and most importantly to deal with the national issue of liability insurance.

This is extremely evident in view of the current crisis of Certified Nurse-Midwives not being able to obtain malpractice liability insurance coverage at an affordable price. This has affected all CNMs accross the country, forcing several people in private practice out of business because of the inability to afford the high premiums for malpractice insurance. Insurance companies say they cannot get enough in premiums from the small number of nurse-midwives to cover even one large litigation. Nurse-midwives
have publicized this crisis in syndicated news articles (McCarthy, 1985) and in local news. The Deseret News of Salt Lake City published an article on November 6, 1985 stating, "High costs of malpractice insurance could drive some midwives out of jobs."

These issues must be addressed by nurse-midifery educational programs for the profession's future survival. Many nursing leaders advocate graduate education in nursing in specialty areas. A closer look at today's needs reveals a dearth of practitioners, educators and leaders prepared at the graduate level to function on a collegial level with other health team members, to participate in and influence health care planning, to act as a patient advocate on the political scene, in other words, a knowledgeable practitioner who has not only technical skills but skills in communication and leadership (Elder, 1976). Optimal communication and leadership skills can best be fostered through the colleague relationship.

Nurse-midwives cannot afford to underestimate the significance collegial relationships have on the success of nurse-midwifery educational programs and nurse-midwifery practice. The colleague relationship is often discussed but rarely understood. Ideally, it is a productive, interactive relationship between faculty members, deans and students for the "common good" within a truly academic milieu. The presence or absence of this relationship is subtle, yet easily recognized by students, colleagues and even clients.

Growth is encouraged, ideas are valued, scholarly activities are respected. The classroom is affected in many ways: teaching is increasingly effective, and course content is validated by the leading edge of nursing knowledge. Students are seen as contributors; therefore, their opinions and questions are sought. The success of a colleague, a superior, or a novice is invested in by all.
Therefore, accomplishments are recognized and success is something in which the group rejoices. (Copp, 1985, p. 188)

The exhilaration of support energizes, infuses confidence and decreases the dreaded burnout syndrome experienced by many faculty, deans and students.

The respondents of this oral history study at the University of Utah revealed a general attitude of sharing a common goal to educate or be educated in order to successfully complete requirements for ACNM certification as well as practice as a CNM. All the respondents were proud of this program even though they may have been confronted with difficult situations. Both faculty and students reflected a sense of growth professionally and/or personally from their experiences at the University of Utah's nurse-midwifery program.

This study has shown repeatedly the importance of a collaborative, collective approach to confront, negotiate and solve conflicts in nurse-midwifery education and service. To assume the University of Utah, or any other graduate nurse-midwifery program could master these broad issues in isolation, within its academic and clinical structure, is not realistic. Our complex society requires a more collaborative effort, similar to the effort employed by the handful of pioneer nurse-midwives who founded the ACNM and started the original educational programs and services in this country. A trend in nurse-midwifery education which would facilitate this collaborative effort is to regionalize nurse-midwifery programs in the western/central United States. The researchers agree with several respondents who stated that regionalization could be a
solution for many of the obstacles within any nurse-midwifery program.

In fact, according to Sharp (1983), CNM cooperative efforts among educational programs were recognized by the program directors as contributing to the success of nurse-midwifery education. The Southeastern Regional Council for the Development of Nurse-Midwifery and the Northeast Regional Council on Education for Nurse-Midwifery (NERCEN) are examples of productive regional approaches to education. Since 1977, the directors of educational programs have met annually to discuss mutual problems and as one director pointed out, an "ethic of sharing" has evolved (Sharp, 1983, p. 21).

Regionalization of nurse-midwifery programs in the western states could result in significant positive effects for all participating programs as has been shown in the established northeastern and southeastern efforts. Easier recruitment of experienced, competent faculty and the obtaining of adequate clinical sites could be positively affected by a regionalization collaborative effort of several nurse-midwifery programs. For example, a network could establish a faculty-exchange program to reduce the effects of faculty inbreeding and to smooth the transition when a faculty position at one school has been vacated and not yet filled.

Joining forces with other nurse-midwifery educational programs in the western regional area of the United States would promote nurse-midwifery through an exchange of clinical practice sites for varied nurse-midwifery student experiences. Such a regional effort would provide a sounding board to express educational issues and concerns. A forum of educators to address these concerns at regular
meetings would offer an opportunity for CNM educators and Directors of programs to share their insights and solutions to various problems. It would also provide channels for reporting this information back to the ACNM national organization. Local chapters of the American College of Nurse-Midwives could further the regionalization effort through development of a joint task force with representatives from each nurse-midwifery educational program to study at educational issues and propose possible solutions.

A regionalization effort would also effect an increase in student applicants. This is becoming a critical issue since the number of applicants has decreased over the past few years to the University of Utah program as well as to other nurse-midwifery programs in this country. One possible cause for the declining pool of applicants is the increasing cost of nurse-midwifery education. This was a contributing factor, reported by respondents in this study, which corroborated with data from the National Education Program Survey for 1984-1986 (Raisler, 1987). In fact, Hsia (1984) believes, "one of the most critical tasks of the 1980s is educating and graduating more nurse-midwives than educational programs are now preparing" (p. 176).

The increasing efforts of faculty and former students, friends and supporters of nurse-midwifery and the various nursing education administrators, both in the state of Utah and in neighboring states, make the success and continuation of the nurse-midwifery program a reality. These efforts cannot be underestimated, yet an increase in collaboration on a collegial level would encourage networking of nurse-midwifery educational programs to reap the benefits of
regionalization. Nurse-midwifery education must continue to prepare graduates to be responsive to trends in clinical practice settings within the context of a complex and evolving society. This study demonstrated that faculty and practitioners gained support in society through knowledgeable use of the political process.

This research study has several limitations which constrain its usefulness. The objectivity of the data presented can be questioned because the researchers had to contend with their own biases resulting from personal beliefs as well as their status as students attending the educational program being studied. Bias also may have resulted due to the fact that the researchers were acquainted in some cases quite closely, with many of the individuals who were interviewed and therefore had already formed opinions about the respondents.

Another limitation which has affected the character of the information obtained is the fact that respondents were not chosen on a random basis. The researchers purposely selected those who have made significant contributions to the evolution of the nurse-midwifery program. These informants were, therefore, not a representative sample of the entire population of students and faculty who have been involved in the historical development of the program.

The task of collecting voluminous amounts of complex and detailed information and then analyzing and interpreting it in a systematic way presented difficulties familiar to historiographers. We encountered these difficulties. Combined with a lack of time in which to master the oral history process before initiating the study,
the dimensions of the task undoubtedly limited our ability to collect and interpret our findings in a leisurely manner.

As a descriptive study of historical trends in nurse-midwifery education in Utah the results cannot be generalized to other nurse-midwifery educational programs. The information obtained and recorded, while interesting and possibly useful to all nurse-midwife educators, is a description of events which occurred in Utah.

The study may well inspire similar research into the historical genesis of other programs; therefore the "Utah experience" reported here could be fertile indeed.

Recommendations for Future Study

It is a recommendation of the researchers that research be conducted to describe the historical development of other nurse-midwifery programs in the United States so that comparisons across programs can be made. We would urge others to utilize the oral history process to obtain their data before the individuals who have been instrumental in advancing the nurse-midwifery profession are no longer able to recount their contributions.

The researchers recommend that research be undertaken to explore, in depth, the historical development of nurse-midwifery practice through the use of interviews with dynamic and dedicated clinicians. It would be of particular importance to explore with these individuals the issue of "burn-out" in the profession and how they have dealt with it. One could hypothesize that supportive collegial relationships positively affect one's attitude thereby increasing one's ability to deal with stress.
Another topic which deserves study is the forces influencing curriculum changes in nurse-midwifery educational programs. For example, researchers could critique the ACNM accreditation site visit reports on programs to compare and contrast subsequent curriculum changes. It would be very useful to discover educators' opinions regarding what percentage of a program's curriculum should be devoted to issues peripheral to clinical practice, i.e., research, nursing theory, the significance of collegial relationships between CNMs and other groups, legislation affecting nurse-midwifery practice and the history of midwifery.

There is a wealth of information obtained from the taped interviews now stored in the Everett L. Cooley Oral History Collection at the University of Utah which was not utilized for this research study. The tapes, in combination with the documents stored in the archives of the University of Utah College of Nursing, could be used to explore in greater depth one or several of the topic areas which we addressed in greater depth. Such research would contribute greatly to deeper understanding of the historical development of nurse-midwifery education, not only in Utah, but in the United States.
APPENDIX A

CONSENT FORM/CONTACT LETTER
CONSENT FORM

Dear ________________________________

We are graduate students in Parent-Child Nursing at the University of Utah conducting historical research regarding the development and history of nurse-midwifery education and practice in the state of Utah. Much of our information will come primarily from oral interviews with key people. Approximately twenty adults will be individually interviewed by one or both researchers in one hour tape recorded sessions. Our research will be published as a Masters thesis to be completed by August 30, 1985. Selected interviews will be in the University of Utah Library Archives as part of the Everett L. Cooley Oral History Collection.

We are requesting your participation in the study by consenting to be interviewed. Confidentiality will be protected. For example, requests for comments to be "off the record" will be respected by the interviewers. Risks to yourself in this type of research are minimal, but may include a potential invasion of privacy if questions are perceived to be embarrassing or confidential in nature. Participants will have the opportunity to review transcription(s) before the tape and transcription are archived and you may restrict any information by requesting statements be removed from the tape and transcription in consideration of self and/or the rights of third parties. You may, of course, discontinue participation at any time.

Benefits to the participants (narrators) include an opportunity to have their viewpoints expressed concerning their own and others' past and present contributions to the development and promotion of nurse-midwifery in Utah. We hope to analyze the data to increase understanding of contributions of nurse-midwifery to maternal-child health in Utah, and nurse-midwifery future trends.

For any question you may have about the research, your rights as participant, or related matters, please contact Lisa Litton in Salt Lake City at (801) 582-1330 anytime. Jan Brugel will be out-of-state February through March for advanced practicum.

We realize that your participation is voluntary and very valuable to us to complete our data collection. Thank you.

Sincerely,

Jan Brugel

Lisa Litton

I have read the above and agree to participate in this study.

Signed ________________________________

Date ________________________________
APPENDIX B

EVERETT L. COOLEY ORAL HISTORY PROJECT FORMS
<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Date of Interview</th>
<th>Date of AWC</th>
<th>Date to Intvee.</th>
<th>Date Re-returned AWC</th>
<th>Date to Final from AWC</th>
<th>Final to Intvee/SPC</th>
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To the Interviewee and Interviewer:

In reviewing this oral interview there are some points that need clarification and we ask that you pay particular attention to them. As a participant in the interview you are the most knowledgeable concerning these items and we want to have as correct and complete a transcript as possible.

You will see question marks within parentheses which indicate the transcriber had difficulty understanding something on the tape. The question may concern a name, a word, spelling, a phrase, or the meaning of a sentence. Please check carefully and add, delete, or correct the question and strike out the question mark or it will appear in the final version of the interview. If you are unable to answer the question, please indicate so in the margin and the tape will be checked again by the transcriber.

Please pay special attention to spelling—especially proper names, technical terms, colloquialisms, and foreign words and phrases.

Attached is a release form for your signature. We cannot complete this final transcript without the signed release which allows the interview to be used by researchers. If you have signed a release form previously, please disregard this request.

You will be furnished two copies of the final transcript of your interview in appreciation for your participating in the oral history program. Additional copies may be purchased for $5.00 each if ordered at the time you return your corrected transcript. Copies ordered later are $10.00 each.

Please return your corrected transcript, signed release, and folder as soon as possible. Thank you.

EVERETT L. COOLEY ORAL HISTORY PROJECT

Attachments
I willingly contribute my testimony recorded on _______ 19____ to the Library of the University of Utah to be used for scholarly purposes.

_____ Open and usable after my review.

_____ Usable with the following restrictions:

__________________________
Interviewee

__________________________
Interviewer
APPENDIX C

LIST OF INTERVIEWEES (KEY INFORMANTS)
<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF INTERVIEW</th>
<th>PLACE OF INTERVIEW</th>
<th>UNIV OF UTAH STUDENT N-M</th>
<th>DATES FACULTY MEMBER/ RELEVANT POSITIONS HELD</th>
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<td>Tyrrel Boehme</td>
<td>12-10-84</td>
<td>Salt Lake City, Utah</td>
<td>1972-1974</td>
<td>1974-1976, Full-time faculty</td>
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<td>1974-1977, Faculty Coordinator of Murray Clinic</td>
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<td>1980-1985, Clinical Faculty</td>
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<tr>
<td>Gail Evans</td>
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<td>Salt Lake City, Utah</td>
<td>1979-1981</td>
<td>1981-Present, Clinical Faculty</td>
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<td></td>
<td>b) 7-2-85</td>
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<td>1983-1985, President of Local</td>
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<td>1985-Present, Maternal Child</td>
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<td>Health Consultant</td>
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<td>LaRita Evans</td>
<td>1-10-85</td>
<td>Provo, Utah</td>
<td>1972-1974</td>
<td>1980-Present, Private Practice</td>
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<td>Joyce Foster</td>
<td>a) 1-21-85</td>
<td>SLC, Utah</td>
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<td>1965-1975, Director of Nurse-Midwifery Program</td>
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<td>1984-1985, Director of Nurse-Midwifery Program</td>
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<td>c) 1-30-85</td>
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<td>1965-present, Faculty Member</td>
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<td>d) 2-6-85</td>
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<td>1971-1976, Chairperson, ACNM</td>
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<td></td>
<td>e) 11-2-85</td>
<td>Moscow, ID to Salt Lake City, Utah, (phone interview)</td>
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<td>NAME</td>
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<td>PLACE OF INTERVIEW</td>
<td>UNIV OF UTAH STUDENT N-M</td>
<td>DATES FACULTY MEMBER/RELEVANT POSITIONS HELD</td>
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<td>Margie Freston</td>
<td>6-22-85</td>
<td>Salt Lake City, Utah to Farmington, CT, (phone interview)</td>
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<td>Mildred Quinn</td>
<td>1-10-85</td>
<td>Salt Lake City, Utah</td>
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<td>1954-1974, Dean, College of Nursing</td>
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<tr>
<td>Sr. Francelyn Reeder</td>
<td>5-7-85</td>
<td>Houston, TX</td>
<td>1971-1973</td>
<td>1973-1979, Faculty and Nurse-Midwifery Education Coordinator, at Shiprock</td>
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<td>b) 1-17-85</td>
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<td>c) 6-26-85</td>
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<td>NAME</td>
<td>DATE OF INTERVIEW</td>
<td>PLACE OF INTERVIEW</td>
<td>UNIV OF UTAH STUDENT N-M</td>
<td>DATES FACULTY MEMBER/RELEVANT POSITIONS HELD</td>
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</table>
APPENDIX D

RESOURCES IN THE ORAL HISTORY PROCESS FOR NURSES:

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APPENDIX E

FOUR TABLES: RESEARCH QUESTIONS WITH CATEGORIES FOR ANALYSIS
TABLE 1

How have the teaching-learning styles of nurse-midwifery faculty at the University of Utah facilitated students' growth and confidence as safe beginning practitioners?

<table>
<thead>
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<th>Teaching-learning styles utilized; faculty perspective</th>
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<tr>
<td>Teaching-learning styles utilized; students' perspective/mentors</td>
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<td>Faculty stress and responsibility; faculty perspective</td>
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<td>Faculty stress and responsibility; student perspective</td>
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<td>Students' perception of growth, competence, and confidence throughout program and when graduated</td>
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<td>What factors influence the success and continuation of a nurse-midwifery program?</td>
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<td>Focus of directors</td>
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<td>Program and ACNM philosophy</td>
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| STUDENTS: |
| Selection, Characteristics and commitment |

| PUBLIC RELATIONS: |
| Media support |
| Consumers |
| Student recruitment |

| STRENGTHS AND WEAKNESSES of the program |

| RECOMMENDATIONS: |
| Suggestions for improvement of the program |
TABLE 3

How is the modern nurse-midwifery student socialized into his/her new role? Are students prepared to meet the challenges of actual practice upon graduation?

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<tr>
<th>STUDENTS Background</th>
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<td>Faculty's approach to socializing students</td>
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<td>NEW GRADUATE TRANSITION</td>
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<td>PREPARED TO BE VISIONARY</td>
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<td>ACNM INVOLVEMENT: Leadership, Commitment to the profession</td>
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</table>
How has the nurse-midwifery program at the University of Utah affected the practice of nurse-midwifery in Utah?

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<th>IMPACT OF THE PROGRAM ON DEVELOPMENT OF PRIVATE PRACTICE IN UTAH</th>
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<th>FUTURE TRENDS IN PRACTICE AND EDUCATION OF NURSE-MIDWIFERY IN UTAH/NATION</th>
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APPENDIX F

LIST OF SIX MAJOR CURRICULUM CHANGES
1. In 1973 the requirement for a minor in educational psychology or psychology was dropped.

2. As clinical sites changed and different ones became available, there were resultant changes in the organization of the curriculum.

3. Reductions in credit hours required by the nurse-midwifery program as mandated by the University of Utah College of Nursing.

4. Major curriculum revisions made during the 1976-1977 administrative reorganization. Core parent-child courses were developed when child, perinatal and nurse-midwifery coalesced.


6. Functional areas (teaching, administration or research were dropped in the mid-1970s as a requirement for all programs within the Graduate School of Nursing (Foster, 1985d).
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