

WOMEN'S LIVED EXPERIENCE WITH  
MIDWIFERY SUPPORT:  
A PHENOMENOLOGICAL STUDY

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**Women's Lived Experience with Midwifery Support:  
A Phenomenological Study**

**by**

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**Dedicated to my husband, David Beaudry, who 'lost' his wife for two years, kept the house in order, cooked meals, supported me emotionally and financially, and did more to prod me towards my goals than he'll ever realize.**

**Abstract**  
**Women's Lived Experience with Midwifery Support:**  
**A Phenomenological Study**

There is a paucity of qualitative research in the literature that focuses on the experience of midwifery support from the woman's perspective. Many researchers have concentrated on other closely related issues, such as the physiological effects on the birth process resulting from a childbirth attendant being present with the laboring woman, the nurse's role during childbirth, or women's satisfaction with the birth experience. Most of these researchers used a quantitative approach. In the present study, phenomenology, a qualitative methodology, was used to explore women's experiences with midwifery support during pregnancy, childbirth, and the postpartum period.

The study included 8 women, 3 primiparas and 5 multiparas. Six of these women were initially contacted regarding participation in the research by the midwife who had supported them through their last labor. Two women heard of the research through friends and approached the researcher themselves. The method of data collection involved taped, unstructured interviews of 30-100 minutes duration, during which participants were encouraged to offer spontaneous verbal descriptions of their experiences.

From the analysis of the interview data, nine common, essential themes were identified. These included (a) midwife as ideal mother, (b) midwife as buffer: ensuring an optimum birth experience, (c) continuity in the midst of fragmentation: the midwife as a known constant, (d) presencing, (e) intuitive knowing, (f) seeking safe passage through the expertise of the midwife, (g)

seeing the whole: the woman as part of a family, (h) maintaining control while letting go, and (i) midwife as trusted and trusting. The themes were not isolated, but were interrelated to form a whole that captured the experience of midwifery support for the women in the study. The significance or essence of the experience was that, for these women, the midwife was seen as an essential and irreplaceable dimension of the birth experience.

The findings stress the need for more continuity of care throughout a woman's pregnancy and childbirth experience, and in particular, highlight the need for the constant presence of a known and trusted caregiver during labor and delivery. Study findings also point to the importance of the health care provider's role in keeping a woman informed throughout the process and allowing her to be a full participant in decisions concerning her care.

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## **CHAPTER 1**

### **Introduction**

The birth of a child can be seen as a pivotal experience for a woman, one which will have an enormous and life-long impact. It has strong sociocultural meaning, serving as a woman's rite of passage into motherhood. The birth process itself can influence how the new mother faces the physical and emotional challenges of motherhood, how she bonds with her new infant, her concept of self as a woman, and how she adjusts to changes in her relationship with her partner (Butani & Hodnett, 1980; Callister, 1993; DiMatteo, Kahn, & Berry, 1993; Simkin, 1991, 1992a). Women's vivid long-term memories of many precise details surrounding the event constitute evidence that childbirth is a deeply felt experience with a powerful effect on women's lives (Bennett, 1985; Simkin, 1991, 1992a; Yarrow, 1982, 1992). The professionals who care for the woman during this special event have the potential to have a positive impact upon the childbirth experience and its outcome (Hodnett, 1996). An individual, such as a midwife, who receives special educational preparation directed towards the support and care of the woman during pregnancy, birth, and the puerperium, should have unique contributions to make to the birth experience of that woman.

Midwives have traditionally provided maternity care for women in most countries around the world. In Canada, however, midwifery almost disappeared around the end of the 19th century due mainly to medical opposition, and has only recently been revived, with legislation pending or passed in several

provinces. This revival has largely been due to consumer demand, as midwives are seen as offering more in-depth, naturalistic, and personalized care (Hanley, 1993; Soderstrom, Chamberlain, Kaitell, & Stewart, 1990). One might assume that women who are cared for by midwives experience the childbirth event somewhat differently than those who choose routine obstetrical care.

Although many studies have investigated women's satisfaction with the birth experience and the role of various health professionals and non-professionals involved in maternity care, most of the researchers employed quantitative methodologies, and very few researchers have sought to examine the woman's experience in any depth. This study was designed to explore the experience of midwifery support during pregnancy, labor, delivery, and the postpartum from the perspective of the women who have given birth. Phenomenology, a qualitative mode of inquiry, was used for this purpose.

The remainder of chapter 1 outlines background information, the rationale, and the research question for the study. Chapter 2 presents a review of the literature relevant to the focus of the research. Chapter 3 describes the phenomenological method, with special attention to the approach as outlined by van Manen (1990). The specific procedures that were followed in the present study are also discussed. Chapter 4 describes the research findings, including the common themes, the relationship among themes, and the essence of the experience under investigation. A discussion of the findings is outlined in chapter 5. The implications for nursing practice, education, and research, the limitations of the study, and the summary are presented in the final chapter.

## **Background to the Study**

Historically, childbirth took place in the home, a familiar environment in which the woman was supported by her family and a traditional female network (Wertz & Wertz, 1979). These caregivers advised, nurtured, and assisted the laboring woman and shared in her experience. Moreover, the woman was in a position to exercise some control over various environmental factors (e.g., number of people present for the birth, positioning adopted for labor and delivery) and able to participate in decisions surrounding the birth process. However, over the last 50-75 years, particularly in most developed countries, childbirth has increasingly become hospital-based and much more technologically focused (Butani & Hodnett, 1980; Callister, 1993; Cook, 1994; Fullerton, 1982; Hodnett, 1996; "Labour Support - RCT", 1995). Many new practices have developed such as continuous fetal monitoring, improved methods of providing analgesia and anesthesia during labor, new methods of induction and augmentation of labor, and changes in the positioning used for labor and delivery (Klaus, Kennell, Robertson, & Sosa, 1986). Meanwhile, in most institutional settings, the laboring woman frequently is unable to avail of the continuous, supportive presence of a nurse (Cogan & Spinnato, 1988). The move into hospital settings has, for the laboring woman, also involved a change to unfamiliar surroundings, loss of extended family support, and loss of control (Bortin, Alzugaray, Dowd, & Kalman, 1994; Littlefield & Adams, 1987; Simkin, 1992b; Willmuth, Weaver, & Borenstein, 1978). Cook (1994) indicated that many individuals believe the increasing medicalization of childbirth has led to a deterioration in women's sense of dignity, fulfillment, and autonomy.

These changes in the management of birth have not gone unnoticed by members of the general public. Women, feminist and parent groups have begun voicing their dissatisfaction with various aspects of antepartum, intrapartum, and postpartum care, and expressing concern about the disease orientation of many obstetrical practitioners. They have emphasized more active roles for women during childbirth, and questioned the need for certain obstetrical practices and interventions (Hanley, 1993; Littlefield & Adams, 1987; Sequin, Therrien, Champagne, & Larouche, 1989; Sullivan & Beeman, 1982; Yarrow, 1982, 1992). Interest has also been renewed in the potential beneficial effect of the labor support person--both lay and professional. In Canada, increasing numbers of pregnant women are seeking midwifery services as an alternative to traditional obstetric care.

The word "midwife" comes from middle English, deriving from the root words "mid" meaning with, and "wife" meaning woman, in the sense of "one who is with the mother" (Allen, 1990, p. 750). The French word for midwife is "sage femme" or wise woman, possibly stemming from medieval times when midwives were considered "good" witches (another name for a good witch was wise woman; Oakley, 1989). Leppert (Thorp, McNitt, Leppert, 1990) indicated that "true midwifery--being 'with woman'--is hard work" (p. 162). She proposed that the most important requirement when caring for the laboring woman is

a caring person to communicate a deep sense of empathy, a sense of truly being with the laboring woman. All women are sensitive to this caring attitude; it literally fills the room; it is palpable. It means touching her, holding her, and letting her and the baby's father know each moment is important, and that the work of labor is significant

and meaningful. (p. 161)

Leppert added that this caring attitude is a learned skill, consciously developed and difficult to acquire. However, it is through this demonstration of caring that an atmosphere of trust is developed.

Historically, many women became midwives because of a genuine desire to care for childbearing women through help and assistance (McCrea, 1993). This desire to help formed the philosophical basis of midwifery practice and is implemented through teaching, guidance, and the provision of social support, encouragement, and physical care. Midwives stress the need to be responsive to the individual needs of each particular woman at any given time. They place strong emphasis on the provision of psychosocial support and also act to enhance and mobilize the mother's own psychosocial resources (Sakala, 1988). Implicit in this philosophical approach is the need for some kind of relationship between the woman and her midwife so that the help and assistance can be given (McCrea, 1993). Exploring the woman's experience with such a relationship may offer insights into the kind of care she values during pregnancy, labor, delivery, and the postpartum.

### **Rationale for the Study**

The beginning ideas for this research originated from my practice as a nurse-midwife. Over the past 6 years, I have been involved with a number of expectant mothers in the community, offering prenatal care, labor support, and postnatal follow-up. The demand for such services has been increasing, particularly over the last 2 years. Upon initial contact, prospective clients

identified various reasons for their interest in midwifery services. For example, they expressed the need to be more informed, a desire to increase their control over the birth process, to have a more natural birth, or to be cared for by an experienced and knowledgeable professional who would be an advocate for them. Postnatally, regardless of birth outcome, these clients expressed profound gratitude, often exclaiming that they "couldn't have done it" without my support. This led me to wonder exactly what it was that these women felt I had done for them during their labor and birth experience. The following question developed: When a midwife enters into a relationship with the mother-to-be and guides her through childbirth, what has the mother gained from that relationship?

From my own involvement and from a number of literature sources (Butani & Hodnett, 1980; Callister, 1993; Cook, 1994), it has become apparent that obstetric care has grown to be more illness-oriented, with emphasis on the use of complex technology and the implementation of various "routine" interventions. Many care providers in the modern labor and delivery unit have become highly-skilled technicians, exceptionally competent at monitoring the physiological aspects of labor and birth, but perhaps less skilled at meeting the psychosocial needs of the laboring woman (Bowes, 1992; Butani & Hodnett, 1980; Kirke, 1980a; McNiven, Hodnett, & O'Brien-Pallas, 1992; Gagnon & Waghorn, 1996). It is also evident that many women are dissatisfied with this type of care (Cunningham, 1993; Sullivan & Beeman, 1982; Waldenstrom & Nilsson, 1993; Willmuth et al., 1978; Yarrow, 1992). Considering that, over the past few years, more women across Canada are opting to involve midwives in their childbirth experience, it is logical to assume that they must be seeking some aspects of care that they are not receiving from standard obstetrical services. Therefore it is

necessary for obstetrical care providers to gain a better understanding of the kind of care that is important to and valued by women during pregnancy, labor, delivery, and the postpartum period. This can be accomplished by listening to women's stories, exploring with them their birth experiences, and identifying the aspects of care that they found valuable and helpful.

The process of birth has been studied extensively over many years. Research has focused on numerous aspects of the birth event and women's experiences, such as factors contributing to client satisfaction or dissatisfaction (Brown & Lumley, 1994; Green, Coupland, & Kitzinger, 1990; Sullivan & Beeman, 1989), the role of the obstetric nurse during childbirth (Callister, 1993; Field, 1987; Sheilds, 1978), the effects of various childbirth attendants (e.g., doulas, monitrices) on the birth process and on maternal and neonatal outcomes (Hodnett & Osborn, 1989a, 1989b; Pascoe, 1993), the benefits of alternative birth settings (Littlefield & Adams, 1987; Cunningham, 1993), and the reliability of women's recall of birth events (Simkin, 1991), to name a few. Although this research has contributed much to our understanding of the childbirth event, most of it has been of a quantitative nature. Very little research has focused on exploring women's experiences in any great depth, examining their feelings, attitudes, and values related to their experience of giving birth. In addition, there has been a lack of research focusing on the contributions of a midwife to the woman's birth experience, from the client's point of view.

Initially, the researcher had planned to focus on women's experiences with midwifery support during the labor and delivery event only. The broad question asked of participants at the beginning of the interview, requested that they focus on the midwife's care received at this time. However, all the



participants spontaneously discussed the midwife's involvement from the antenatal period through to the postpartum. They did not view their experience as isolated or fragmented sections, divided into antepartum, intrapartum, and postpartum periods. Therefore the focus of the study was changed to encompass the care and support provided by the midwife to the woman throughout the entire childbirth experience, as this was the experience as lived by the participants.

This study used a qualitative research approach, phenomenology, in order to capture more fully, women's experiences with midwives during pregnancy and birth. It is hoped that the research findings will offer insight into the type of care that women value during this important time in their lives. These findings could be used to promote a more sensitive caregiving approach which effectively meets the needs of childbearing women. The quality of care provided to women during pregnancy, labor, delivery, and the postpartum could be improved, leading to an increased satisfaction with childbirth experience (Bortin et al., 1994; Callister, 1993; DiMatteo et al., 1993; Mackey & Lock, 1989).

### **Statement of the Problem**

The purpose of this study is to expand the body of knowledge regarding midwifery support during pregnancy, labor, delivery, and the postpartum period, by gaining an understanding of the experience from the perspective of the women who were accompanied by a trained nurse-midwife during childbirth. The essential question addressed was: What is it like for a woman to be supported by a midwife throughout pregnancy, childbirth, and the puerperium?

## **CHAPTER 2**

### **Literature Review**

A considerable amount of research has been conducted on various aspects of the birth process and the role of caregivers participating in this event. In addition, the literature contains non-research material such as commentaries and articles which discuss childbirth and obstetric health care. The majority of the published research has been quantitative in nature, and very few researchers have attempted to investigate the women's perspective. There are, however, articles and books available which offer anecdotal accounts of women's experiences during labor (e.g., Harwood, 1988; Hutton, 1988; Kitzinger, 1977; Perez & Snedeker, 1990; Taylor, 1991). These narratives offer some insight into what the experience is really like for women who have given birth.

The remainder of the chapter provides an overview of the relevant literature that has contributed to a partial understanding of women's experiences with childbirth. The first section reviews literature exploring the midwife-client relationship. The second section outlines literature pertaining to the influence of various professional and non-professional support persons on labor outcome. The third section summarizes the research literature concerning the role of the obstetric nurse in labor support. The final section highlights research which examined various predictors of women's satisfaction with the birth experience.

### **The Midwife-Client Relationship**

When conducting the literature search, only one study was found that specifically addressed the midwife-client relationship, and this was from the perspective of the midwife (McCrea, 1993; McCrea & Crute, 1991). This qualitative study explored midwives' understanding of the factors which affected the development of a therapeutic relationship with clients. Four main issues were identified: the nature and value of the midwife's role, recognition of authority and autonomy in practicing this role, maintenance of personal integrity, and emotional involvement with clients (McCrea & Crute, 1991). With regard to the latter theme, midwives felt that emotional involvement represented performing their job most effectively and in the most satisfying manner. As one midwife indicated "the best comes out of me when I can feel with the mothers" (McCrea & Crute, 1991, p. 188). When discussing the limitations of their research, McCrea and Crute acknowledged that the study had focused upon only one of the parties involved in the relationship. They suggested that future research investigating health professional / client relationships should recognize the importance of clients in defining the relationship.

Sakala (1988) used in-depth interviewing with a group of 15 independent midwives in Utah to examine the care they offered clients, particularly related to pain relief in labor. In her summary, she described the following unique characteristics of the midwifery practice of her group: (a) the building of a trusting relationship with the woman, (b) in-depth client education, (c) responsiveness to the wishes of the woman / significant others, (d) respect for the knowledge, resources, and capabilities of the woman / significant others, (e)

prenatal and intrapartum empowerment of the woman / significant others (f) commitment to innovation and experimentation, (g) individualization and simplicity of techniques, and (i) provision of intrapartum support early in labor. This study involved lay as opposed to trained midwives so one cannot be sure these findings would apply to other categories of midwives (i.e., direct entry, nurse-midwives). In addition, this study did not explore the experiences of clients to determine if these characteristics would be important aspects of midwifery care for them.

In another study, researchers did address the experience of midwifery care from the woman's perspective. Bluff and Holloway (1994) used a grounded theory approach to examine women's experiences with childbirth. Unstructured, tape-recorded interviews gave participants an opportunity to express their thoughts and feelings regarding the birth experience and the professionals who had cared for them. Eleven women were interviewed, all of whom were cared for by midwives during labor, and all but one were delivered by a midwife. Findings showed that women wished to take an active part in the control of labor, yet paradoxically, the women trusted their midwives, saw them as the experts who knew best, and thus gave the midwives the authority to make decisions concerning their care, even at times when the women were unsure as to why some decisions were being made. The researchers indicated that the study findings identified a need for a flexible relationship between women in labor and their midwives. They stated that although the midwives in this study tended to be placed in a position of authority by the women they cared for, a relationship based on equality might be more effective and would serve to empower the women. They expressed the belief that "it is . . . important for midwives to

explore and discover the wishes and feelings of [the women] in their care" and "communicate with their clients in order to mutually agree on the most appropriate type of relationship and care [required]" (p. 163). Midwives must be willing to share their knowledge and also to respect the woman's expertise, which stems from "intimate knowledge of her own body" (p. 163).

Although there is a lack of research literature addressing the midwife-client relationship from the woman's perspective, there are a number of published anecdotal reports written by mothers which indicate that this relationship can have an important positive or negative impact on them. Women describe vivid memories of the midwives who have cared for them, even many years after the event (Harwood, 1988; Kitzinger, 1977; Lautman, 1988; Taylor, 1991; Wright, 1989). Harwood (1988) writes the following with respect to her midwife, Lyn, and the care she offered: "She was lovely: calm, kind, competent, blessed with common sense and she *listened* to me! What more could anyone ask for?" (p. 267). "I knew that [she] would give whatever help I might want or need. . . . I felt in good hands, cherished and respected" (p. 268). Hutton (1988), who described women's memories of their midwives' care during pregnancy, labor, and the postpartum, included these comments: The women felt that their midwives were "really interested in helping them", offered "undivided attention", gave "support, explanations, encouragement . . . [and] consulted the mother about her wishes" (p. 273). These comments suggest a very special relationship between the midwives and the clients they cared for during pregnancy and childbirth.

### **The Influence of a Support Person on Labor Outcome**

Advances in technology and the movement of childbirth into the hospital setting have positively influenced rates of maternal and perinatal mortality. The likelihood of a healthy pregnancy outcome for both mother and infant has increased significantly in the developed world during the 20th century (Littlefield & Adams, 1987). Despite these advances, it has been suggested that the communication of caring and support during labor can contribute as much, or perhaps even more, to the health of the childbearing woman as obstetric technology (Bowes, 1992; Butani & Hodnett, 1980; Callister, 1993; Kintz, 1987; Kirke, 1980a; Oakley, 1989). This focuses attention on the potential positive effects that either a professional or nonprofessional birth attendant or a trained professional working in the labor and delivery setting could have on the woman's birth experience.

The importance of a birth companion (or labor support person) was inadvertently discovered by Haverkamp, Thompson, McFee, and Cetrulo in 1976. These researchers designed a prospective, randomized controlled trial in order to compare continuous fetal monitoring (electronically monitored group; 242 women) to intermittent auscultation (auscultated group; 241 women). Although perinatal outcome was not significantly different among the two groups, the women who had undergone intermittent monitoring had a significantly lower cesarean delivery rate and fewer fetal heart tracings indicating uteroplacental insufficiency. Haverkamp et al. (1976) proposed that the auscultated group experienced more individualized nursing care and close physical contact for the purpose of auscultating the fetal heart. They suggested that this added attention

and physical contact may have resulted in less anxiety and thus more favorable outcomes for the women in this group.

In the wake of these unexpected results, other researchers have conducted a number of quantitative studies to further investigate the effects of various types of birth attendants on birth outcomes. These studies involved the use of untrained or minimally trained labor companions or "doulas" (Hofmeyr, Nikodem, Wolman, Chalmers, & Kramer, 1991; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991; Klaus et al., 1986; Pascoe, 1993; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980), trained childbirth educators (Cogan & Spinnato, 1988), and self-employed labor coaches or monitrices (lay midwives or midwives-in-training; Hodnett & Osborn, 1989a, 1989b). The labor companions (doulas) provided only emotional support (e.g., encouragement and praise) and limited physical care (e.g., touch, backrubs) to the laboring woman. Monitrices and childbirth educators provided these aspects of care as well as informational support (e.g., instruction, explanations) and advocacy. Few studies were found that involved trained professionals such as labor and delivery nurses or nurse-midwives. Hemminki et al. (1990) reported on two trials using midwifery students as birth attendants, and Breart et al. (1992) described a European trial in which midwives or student midwives gave continuous professional support to women in labor. The student midwives in these studies were expected to provide all the usual care that midwives normally do.

The results of these studies indicated a wide range of benefits to the women in the experimental groups who received continual labor support. These benefits included reduced length of hospital stay from admission to birth, fewer interruptions in the normal progress of birth (Hemminki et al., 1990), shorter

duration of labor (Breart et al., 1992; Kennell et al., 1991; Klaus et al., 1986; Pascoe, 1993; Sosa et al., 1980), fewer abnormally long labors (Cogan & Spinnato, 1988), less need for oxytocin augmentation (Klaus et al., 1986), reduced rate of epidural anesthetics, vacuum and/or forceps deliveries (Breart et al., 1992; Kennell et al., 1991), more intact perineums (Hodnett & Osborn, 1989a), reduced rate of cesarean delivery (Kennell et al., 1991; Klaus et al., 1986), improved neonatal well-being (Cogan & Spinnato, 1988), increased maternal-newborn interaction (Sosa et al., 1980), and increased success with breastfeeding (Hofmeyr et al., 1991).

Almost all of these studies were strong experimental designs (i.e., randomized, controlled trials) and involved adequate to large numbers of subjects. However, a number of the studies, which demonstrated the beneficial effects of doulas, were conducted with low socioeconomic populations. It is not certain that the same benefits would be found with women of higher socioeconomic status. Indeed, in the research by Hodnett and Osborn (1989a), who studied groups of middle-class women in Toronto, fewer beneficial outcomes were observed. In addition, most of these studies involved informally or minimally trained attendants. Therefore, there is still a need for more research to investigate whether or not obstetric nurses or trained midwives, on a one-to-one basis with the woman, could provide emotional support during labor equivalent to that of a birth attendant and produce the improved outcomes noted above (Bowes, 1992).

Finally, the above studies, for the most part, identified specific physiological outcomes that resulted from labor support. It would be advantageous to identify and explore the less tangible benefits as experienced



by the women themselves. Hofmeyr et al. (1991) did indicate that the support group of women was more likely to report that they felt they had coped well during labor, and mean pain and anxiety scores were lower for this group. The new mothers in the study by Hemminki et al. (1990) completed questionnaires indicating the aspects of the support person that had pleased them the most. "Mere presence," "the explanations she gave," "what she said for encouragement," and "the physical support she gave" were options most often selected (p. 247). However, this superficial data only offers a glimpse of the rich source of information women could provide regarding the perceived benefits of support offered by their caregivers.

### **The Role of the Obstetric Nurse in Labor Support**

In most labor and delivery units in Canada, it is the nurse who cares for the laboring woman, conducting the necessary monitoring, providing attention to physical needs, and offering emotional support. A review of relevant literature examining women's perceptions of their nursing care needs should contribute some insight into the type of care and support that is valued by women during their childbirth experiences.

Women's perceptions of and satisfaction with nursing care and women's perceptions of their nursing care needs have been the focus of a number of research investigations, beginning with a study by Lesser and Keane in 1956. This study identified the needs of laboring women as including the need to (a) be sustained, (b) be assured of a safe outcome for self and baby, (c) have caregivers accept her personal attitude toward and behavior during labor, (d)

receive bodily care, and (e) have relief from pain. A number of quantitative, and a few qualitative studies have been completed since this time, building upon the work of these two researchers.

Shields (1978) interviewed 80 postpartum mothers, using an interview questionnaire, to obtain their descriptions of the nursing care received during labor and delivery, the most helpful nursing measure received, and their satisfaction with nursing care received. Responses were categorized into seven types of care: supportive, physical, medications, and combinations of these three. The respondents indicated that combined care was very satisfying, however, it was supportive care (e.g., hand-holding, assisting with breathing, staying with the woman, encouragement, explanations) that was the decisive factor in the way these women viewed their nursing care. The most frequently mentioned aspect of supportive care was "the ability of the nurse to be a sustaining presence" (p. 535), as well as her ability to assess the patient's need or non-need for her presence at any given time (selective presence).

Similarly, Field (1987) used semistructured interviews with a group of 44 postpartum mothers, in order to assess their satisfaction with care in labor and delivery and the postpartum period. The study subjects identified a number of positive labor and delivery nurse characteristics and behaviors: providing personalized care, acting as a patient advocate, offering encouragement and praise, responding to questions, conveying a sense of security and confidence, being friendly and knowledgeable, and listening to and respecting the mother's opinion. Field indicated that satisfaction with the childbirth experience increased when women believed they were being treated with respect, were kept informed, and felt confident about the nurse's competency.

For her study of nursing support in labor, Kintz (1987) designed a questionnaire, identifying 20 supportive labor and delivery nursing behaviors. These behaviors were classified into three groups: affect, affirmation, and aid support. This questionnaire was then administered to 78 postpartum women who were asked to rate the helpfulness of these behaviors. All behaviors were perceived as helpful, however, the following six were rated as most helpful: coaching, praising the woman's efforts, providing friendly and personal care, accepting the woman's behavior, treating the woman with respect, and making the woman feel cared about as an individual. Kintz pointed out that five of these six behaviors involved interpersonal dynamics and involved the subscales of affect and affirmation. Of the three subscales, aid received the lowest scale mean. Kintz concluded that "interpersonal skills are at least as important as technical skills, if not more so" (p. 130).

Results very similar to the above studies were obtained by Callister (1993). She used semistructured interviews and a combination of qualitative and quantitative analyses to describe the perceptions of 26 primiparous mothers regarding the nurse's role during childbirth. Overall, participants expressed satisfaction with nursing care received, and their responses with respect to nursing care behaviors could be categorized into three broad domains: emotional (affective affirmation), informational, and tangible (physical / aid) support. The author concluded that sensitive, individualized care is important in order to effectively meet the needs and expectations of childbearing women.

Bryanton, Fraser-Davey, and Sullivan (1994) also combined qualitative and quantitative approaches to investigate women's perceptions of nursing support during labor, using an adaptation of Kintz's (1987) labor questionnaire.

Eighty women were asked to rate 25 nursing support behaviors which were categorized according to Lazarus' model of social support: emotional, tangible, and informational support. All behaviors were perceived as helpful, and as in previous studies, behaviors perceived as most helpful were in the emotional support category. The most helpful behaviors included: making the woman feel cared about as an individual, giving praise, appearing calm and confident, assisting with breathing and relaxation, and treating the woman with respect.

Collins (1986) also focused on the role of the nurse in labor and delivery as it was perceived by both the nurses themselves and a group of expectant women. Twenty-one pregnant women and 27 labor and delivery nurses were asked to complete a Q-sort, each card of which identified a particular nursing behavior. Results showed that both the women and the nurses had similar perceptions of the importance of the 50 behaviors identified, and Collins suggested that labor and delivery room nurses generally meet the expectations of expectant mothers.

Mackey and Lock (1989) used in-depth interviews and a qualitative data analysis to identify seven themes or categories which best captured women's expectations of nursing care during labor and delivery. Sixty-one multigravidae were interviewed and the following categories were identified: presence, decision-making assistance, physical assessment, information, comfort, and support. Although these findings were similar to those of previous investigations, one finding was not. The women in this study differed in the nature and amount of involvement they desired from nurses during labor and delivery. Some of the women expected limited nurse involvement in decision-making and minimal presence by the nurse. Other women desired moderate nurse involvement,

expecting the nurse to be present on a regular but intermittent basis. Finally, there was a group of women who wished for extensive involvement by the nurse with regards to time spent with the client and participation in labor management. The authors pointed out that childbearing women may well have varying needs and expectations for nursing care. It is important for nurses to assess each client individually to determine the level of nurse involvement that is preferred.

Mackey and Stepan (1994) indicated that although these previous studies had made important contributions to the body of knowledge regarding women's views of labor and delivery nurses, most were limited in scope and depth, and failed to capture women's full accounts of their labor and delivery experiences. They designed a qualitative study, using intensive interviewing with open-ended questions. Findings indicated that 90% of the 61 participants evaluated their nurses favorably. Once again, the provision of supportive care emerged as being most important. When women's comments were grouped in terms of recurring themes, six categories were noted: positive participation by the nurse in the labor and delivery, acceptance, information-giving, encouragement, presence, and competence. The authors indicated that their results confirmed the research conducted by Kintz (1987) who suggested that nurses' interpersonal skills are as important as their technical skills. In addition, the nurses who were viewed most favorably were those who had "the ability to discern when their presence was needed and when women desired privacy" (Mackey & Stepan, 1994, p. 419). This finding reinforces the results of the study by Mackey and Lock (1989).

Considering the favorable results of the above studies in which most women were highly satisfied with their nursing care, a study by McNiven et al.

(1992) of the activities of labor and delivery nurses, produced findings which seem contradictory. This study piloted a work sampling method, adapted to determine the proportion of time the nurse spent in supportive care activities (e.g., emotional support, physical comfort measures, information giving, advocacy). Eighteen nurses in a Toronto teaching hospital participated and 616 random observations were made. Results indicated that only 9.9% of the nurses' time on the day shift was spent in supportive activities. The supportive subcategories of physical comfort measures and advocacy appeared to be virtually absent. The authors concluded that technologic tasks tended to be more highly valued and occupy more of the nurses' time. Meanwhile, "support and other aspects of interpersonal care have not been formally recognized [or] encouraged" among labor and delivery nurses (p. 7).

A similar study by Gagnon and Waghorn (1996), conducted at a university hospital in Quebec, confirmed the research results of McNiven et al. (1992). These investigators also used a work sampling method, however, in this study nursing care was examined over a 24 hour period (versus day shift only), on weekdays and weekends. Observation periods were randomly selected to represent each shift and day of the week and a total of 3367 observations were made. Results showed that only 6.1% of nurses' time was spent in supportive care activities (i.e., physical comfort, emotional support, instruction, and advocacy). Of this time allotted to supportive care, only 17.0% was devoted to being with the woman and offering reassurance, encouragement, and praise. The majority of the nurses' time was spent on providing indirect care out of the room: giving or receiving report, charting, preparing equipment or drugs. The results of both of these studies suggest the need for perinatal caregivers and

administrators to reexamine how nurses spend their time. However, as only two hospitals were involved in the research, caution must be advised in generalizing the results to other centers.

All of the above studies involved only nurse caregivers, and no comparable studies could be found examining midwifery support during labor and delivery. Without this type of research, it is not possible to know if the care offered by midwives is the same as that given by nurses, or if clients would identify similar midwifery care behaviors as being helpful and not helpful. At the present time, with increasing numbers of women across Canada expressing interest in, or actively seeking midwifery services, one is left to wonder what it might be about midwifery care that women value so highly.

### **Satisfaction with the Birth Experience**

Results of research studies and narrative accounts of women's birth experiences suggest that the birth event has a powerful effect on women's lives (Butani & Hodnett, 1980; Callister, 1993; DiMatteo et al., 1993; Harwood, 1988; Kitzinger, 1977; Perez & Snedeker, 1990; Simkin, 1991, 1992a; Yarrow, 1992). Women can emerge from this experience with both positive and negative memories of the care received, their own performance, and the outcome of their efforts. Persons who provide care for laboring women need to be aware of specific factors which could help ensure that women emerge from this experience with a sense of satisfaction and fulfillment, as opposed to dissatisfaction and disappointment.

Satisfaction, in the context of childbirth, refers to "the experience of the woman and her support system, and to [the] congruence between her expectations and actual outcomes" (Bortin et al., 1994, p. 144). Over the years, researchers have designed various types of studies in an attempt to measure women's satisfaction with childbirth and with different types of care providers and birth settings (Brown & Lumley, 1994; Cunningham, 1993; Sequin et al., 1989; Sullivan & Beeman, 1982). It appears that a major thrust in this research is not so much to identify whether women are satisfied or dissatisfied with perinatal care, but to identify the factors which impede or enhance a positive perception of the event. A number of possible predictors of patient satisfaction have been suggested and researched by investigators. The following subsections will include a discussion of several of these predictors, with emphasis on those that are of most relevance to the present study.

**Self control.** Control is a concept that has several meanings, and in the context of birth, control may be defined differently by individual women. When examining qualitative studies that have explored with women the meaning of control during childbirth, the following two definitions were noted most frequently: (a) self control: the ability to retain control over one's emotions and actions; behaving in a planned, prescribed manner, and (b) the sense of being an active participant: having control in interpersonal relationships with the staff and control over what was happening to one's body (Chertoc, 1967; Simkin, 1991; Willmuth, 1975; Yahla & Ulin, 1965). It is the first definition which will be explored in this section.



There are few studies that have examined patient satisfaction in relation to measures of self control during childbirth. Green et al. (1990) investigated the relevance of control for childbearing women by means of a mailed questionnaire that was sent to 1150 women in Southeast England (825 were returned in usable condition). Women who felt they were in control of their behavior during labor and delivery had significantly higher satisfaction scores. Women who did not feel in control of themselves were least satisfied, least likely to feel fulfilled, and had low postnatal emotional well-being. In a study by Butani and Hodnett (1980), women who expressed regrets about their birth experience most often indicated a loss of control over their behavior during labor as the reason why they had these regrets. Although limited in number, these studies seem to indicate that behaving according to one's ideals or expectations is important to women during labor and delivery.

**Participation in decision-making.** Researchers using qualitative methods to examine the reasons women give for their satisfaction (or dissatisfaction) with childbirth often report a theme of control. When trying to understand what this concept really involves, the most frequently uncovered meaning was that of a sense of control in interpersonal relationships with staff. It was described as an ability to influence the decisions made during labor and delivery and remain an active participant. Self-sufficiency and a sense of autonomy were important for women. It was not desirable to surrender all decisions and responsibilities to the staff who would then take over (DiMatteo et al., 1993; Simkin, 1991; Willmuth, 1975). Simkin (1991) interviewed women 15 to 20 years after the birth of their first child and observed that control over what

had happened and participation in decision-making during birth were important factors in long-term satisfaction. Even after this lengthy period of time, women reported that being in control had enhanced their self-confidence and self-esteem.

A review of quantitative studies that focused on women's satisfaction with childbirth revealed results which supported the above findings: satisfaction with participation in decision-making was one of the most important factors associated with overall satisfaction with medical services, nursing or midwifery care, and the childbirth experience. Other important factors (which closely relate to control and decision-making) included amount of information provided, satisfaction with explanations received, and quality of communication with care providers (Brown & Lumley, 1994; Cartwright, 1987; Davenport-Slack & Boylan, 1974; Drew, Salmon, & Webb, 1989; Green et al., 1990; Humenick & Bugen, 1981; Kirke, 1980b; Sequin et al., 1989; Sullivan & Beeman, 1982).

Sequin et al. (1989) used a random, systematic, stratified sampling method to select 1790 mothers for a retrospective study of women's satisfaction 4 to 7 months postpartum (response rate 52.4% or 938 subjects). This is one of the few studies which included a representative sample of women in terms of years of education (range: 3-22 years, approximately 35% had less than 11 years). The results indicated that participation in the decision-making process and frequency of explanations received contributed significantly to feelings of satisfaction for all women. This assists in challenging the myth that only well-educated women want to have increased control over their childbirth experience.

**Locus of control.** Locus of control is another concept that has been examined in relation to the issue of patient decision-making and satisfaction. Locus of control is a theoretical framework from social learning theory, originally described by Rotter in 1966. It is viewed as a continuum on which individuals at one extreme perceive that life events and outcomes are primarily a consequence of their own actions and behaviors (internal locus) while individuals at the other extreme view life events primarily as imposed from without (external locus). Those with an external locus of control believe outcomes are due to forces such as luck, fate or chance, or to powerful other people and are beyond personal control (Fullerton, 1982; Humenick, 1981; Littlefield & Adams, 1987; Willmuth et al., 1978).

Researchers following the locus of control framework, have suggested that increasing satisfaction with childbirth is not a simple matter of increasing a woman's degree of control and participation during labor and delivery. The hypothesis that has been formulated is that women with an internal locus of control would be more satisfied with an experience in which they were active participants, while women with an external locus would rate more highly an experience that was controlled by their care providers (Aaronson, 1987; Fullerton, 1982; Willmuth et al., 1978).

Women who had an internal locus of control more often sought alternative birthing arrangements (Cunningham, 1993; Fullerton, 1982), attended childbirth preparation classes (Willmuth et al., 1978), and sought midwives as care providers (Aaronson, 1987). On the other hand, women with an external locus expected powerful others (e.g., doctors) to make decisions for them. They sought the safety of hospital births (Cunningham, 1993; Fullerton, 1982), and the

usual doctor-patient relationship (Aaronson, 1987). Prenatal classes, which encourage active participation in childbirth, may be viewed negatively by these women (Willmuth et al., 1978). Fullerton (1982) suggested that individuals who are willing to surrender control and decision-making are best served by obstetrical policies that provide such a structure of support. Alternatively, those women who wish to retain control can be better served by an environment that encourages freedom of choice.

All of the above studies involved a non-experimental, descriptive or retrospective correlational design and in some instances, had low response rates to questionnaires. This must be taken into consideration when drawing conclusions from these studies. In addition, there have been studies conducted that call into question the notion that satisfaction with childbirth varies depending on locus of control and amount of participation desired and actually experienced (Bradley, Tashevskaya & Selby, 1990; Littlefield & Adams, 1987). Littlefield and Adams (1987) employed a quasi-experimental, two-group design to study health locus of control, patient participation in and satisfaction with care in childbirth. No significant relationship between internal locus of control and satisfaction was found for either group. Powerful other scores (indicating external locus of control) actually increased for both groups post delivery, indicating, the authors suggested, a recognition of the essential role health care providers do play in the perinatal period.

Humenick (1981) proposed a Mastery Model to explain childbirth satisfaction. She discussed childbirth as a psychologically important task for all women and indicated that control or mastery of that task is closely related to overall satisfaction. She suggested that effective childbirth preparation, whereby

expectant mothers are encouraged to become informed, set goals, learn coping skills, and prepare for active participation, may actually increase internal locus of control, self-esteem, and satisfaction with a birth experience that fostered maternal control. This theory was later supported by the results of a quantitative study of a small group of primiparas (Humenick & Bugen, 1981). Although this study involved a small sample of highly educated and motivated women and no control group was used for comparative purposes, it does stimulate interest in the concept of mastery. If all women, regardless of locus of control, desire a sense of mastery over the birth experience, then decision-making skills and the "how-to" of becoming an active participant can be taught prenatally, encouraged during labor and delivery, and thus lead to increased feelings of satisfaction with childbirth.

**Type of caregiver.** Because of the different philosophies underlying the care provided by obstetricians, family physicians, and midwives, the type of caregiver may influence a woman's satisfaction with labor and delivery. Few studies have directly compared midwifery practice with that of physicians in terms of patient satisfaction, and results vary in terms of what was actually examined in these studies.

Some researchers found that satisfaction did not vary according to the primary caregiver assisting with the birth (Brown & Lumley, 1994; Rooks, Weatherby, & Ernst, 1992a, 1992b). Rooks et al. (1992b) observed that most of the women studied indicated that they would choose the same kind of clinician (obstetrician, family physician, nurse-midwife, or lay midwife) for a subsequent birth, however, this was more often the case for women who had been attended

by a certified nurse-midwife. Women also rated midwives more positively on scales measuring caregivers' attitudes and sensitivity. In other studies of caregivers, women rated midwives more highly than physicians with regards to factors such as support, encouragement, and practical help offered during labor (Bennett, Hewson, Booker, & Holliday, 1985; Cunningham, 1993). Soderstrom et al. (1990), who surveyed women in Ontario about their interest in midwifery care, noted that midwives were most often selected (versus family doctors, obstetricians, nurses, and prenatal instructors) for education, counselling, and support throughout pregnancy, labor, birth, and the postpartum period.

A randomized, controlled trial was conducted in Tooting, England from 1983 to 1985, as part of a 'Know Your Midwife' scheme (Flint, 1986, 1988; Flint, Poulengeris, & Grant, 1989). In this trial, 1001 pregnant women were randomized into two groups. One group of women received antepartum, intrapartum, and postpartum care from four midwives who were part of the 'Know Your Midwife' (KYM) scheme. This scheme was designed to improve continuity of care to expectant mothers. The other group received the usual hospital-based care, which included antenatal care given by doctors, and intrapartum care offered by hospital midwives and doctors. Results of the study indicated that the KYM scheme was associated with greater continuity of care, maternal reports of increased control during labor, and increased maternal satisfaction. More women in this group rated their caregivers as "very caring", stated that they were encouraged to ask more questions, had all choices explained to them, and felt better prepared for labor. The women in the KYM scheme indicated that their midwives were interested in them as a person, and were more likely to describe their labor as "wonderful" or "enjoyable". The researchers suggested that the

increased satisfaction could be due to the fact that the women in the KYM group were able to build a relationship with the midwife/midwives they encountered, considering there would only be four or fewer midwives providing care. Often, the women receiving standard care were seen by a number of caregivers, for example, 51% of these women reported being seen by eight or more caregivers antenatally.

None of the above studies compared women who had been cared for by different professionals at two different birth experiences. Therefore, it may be difficult for the women to truly compare the total range of care offered by a midwife versus that offered by the family doctor, for instance. In addition, all of these studies used quantitative methodologies and did not fully explore the woman's experience with her caregiver in any depth.

**Other predictors of childbirth satisfaction.** A number of other variables have been considered as potential predictors of a woman's satisfaction with her childbirth experience. These include variables such as birth setting (Bradley et al., 1990; Cunningham, 1993; Littlefield & Adams, 1987; Rooks et al., 1992b; Waldenstrom & Nilsson, 1993), prenatal preparation (Butani & Hodnett, 1980; Cunningham, 1993; Davenport-Slack & Boylan, 1974; Doering & Entwisle, 1975; Sequin et al., 1989; Willmuth, 1975; Willmuth et al., 1978), amount of pain during labor (Brown & Lumley, 1994; Davenport-Slack & Boylan, 1974; Green et al., 1990; Morgan, Bulpitt, Clifton, & Lewis, 1982; Sequin et al., 1989), the number of medical interventions experienced during labor and delivery (Brown & Lumley, 1994; Butani & Hodnett, 1980; Drew et al., 1989; Green et al., 1990; Sequin et al., 1989), and certain sociodemographic or pregnancy variables

(e.g., parity; Brown & Lumley, 1994; Cunningham, 1993; Green et al., 1990; Littlefield & Adams, 1987; Sequin et al., 1989).

These studies often produced conflicting results and no single factor emerged as one that could explain all the variation in patient satisfaction. However, in many instances, the above variables were noted to be closely interrelated with the predictors of control and increased patient participation in decision-making. For example, results of the research investigating pain during labor indicated that the pain of labor is an emotional and complex matter and is closely related to feelings of being in control of self and the environment. Davenport-Slack and Boylan (1974) suggested that women who have a positive attitude towards pregnancy, who expect to and do participate in decision-making during labor, may experience a high degree of pain but still report high levels of satisfaction with the birth experience. Similarly, with regards to the number of medical interventions during labor, if the woman still feels she is in control of what is happening and is given the opportunity to participate in decision-making regarding the interventions, feelings of satisfaction with the overall experience may not be affected (Green et al., 1990).

**Summary of satisfaction studies.** Much of the above research can be criticized for the type of design employed (i.e., many studies were non-experimental, descriptive or retrospective correlational in nature), the use of convenience sampling (limiting generalizability of results), in some cases, low response rates to mailed questionnaires, and the surveying of responses too soon after birth (the birth of a healthy baby may compensate for any negative experiences; the "halo effect" as described by Bennett, 1985; Bramadat &



Driedger, 1993; Sequin et al., 1989). In addition, some researchers argue that satisfaction is not a concept which can be measured quantitatively (Bortin et al., 1994; Lumley, 1985; Shearer, 1983). As Lumley (1985) stated "satisfaction with birth is a complex, subtle and constantly changing collage of memories, reflections, beliefs, reactions and convictions, remembered by a series of active and even creative processes" (p. 144). This suggests that qualitative research may be better able to capture a woman's feelings regarding the childbirth event.

Despite the limitations of these studies, they do contribute to our knowledge and understanding of the woman's perception of the childbirth experience. The results seem to suggest that increased patient involvement in the birth process has a great impact on intrapartum satisfaction. The underlying philosophy of midwifery care emphasizes minimum intervention, increased client control, and self-determination. Midwives believe that every childbearing family has the right to participate in and make choices for their birth experience (Aaronson, 1987; Bortin et al., 1994; Hanley, 1993; Sakala, 1988; Scupholme, 1982; Soderstrom et al., 1990). It would seem plausible then, to suggest that the increased ability to participate in decision-making surrounding their own birth experience may be a factor as to why women choose midwives for labor support.

### **Summary of the Literature Reviewed**

It is evident from the preceding literature review that there has been little research conducted to date which focuses specifically on the experiences of women with the care provided by midwives during pregnancy, birth, and the puerperium. Much of the research has been quantitative in nature and has

tended to focus on the physiological effects on birth outcomes resulting from the presence of untrained or minimally trained birth companions, the role of the nurse during childbirth, and the predictors of women's satisfaction with the childbirth experience.

Although quantitative research has contributed to our understanding of events surrounding childbirth, it does not adequately capture the woman's full experience. Participants do not have the opportunity to tell their whole story and are restricted to responding to pre-determined questions and selecting structured options. In one quantitative study examining maternal satisfaction with maternity care, 39 women who had been cared for by midwives during a planned home birth, and some women who had utilized midwives in hospital settings, attached letters to their questionnaires outlining the benefits of midwifery care, such as improved rapport, more open communication, greater flexibility, and more control over the birth experience (Sullivan & Beeman, 1982). This self-directed action by the women in this study--of attaching a letter to the structured questionnaire--indicated that the quantitative method of surveying women regarding their childbirth caregivers did not adequately capture the women's experience with these caregivers. A qualitative method of inquiry would allow a much richer description. For example, in a narrative account of her childbirth experience, Taylor (1991) refers to her midwife as providing an invaluable shield. "The sense of safety she conveyed . . . helped transform my experience of contractions from one of overpowering agony to one in which I became a conduit through which massive energy was surging" (p. 66). This rich description cannot be obtained from a questionnaire or structured interview.

A number of investigators have expressed the need for research that explores the role of midwives during labor and delivery. Callister (1993) indicated that it would be beneficial to replicate and extend her study on the role of the nurse in childbirth, to women who had nurse-midwives as care providers. Soderstrom et al. (1990) proposed the following research question: Of the women in Canada who have recently used midwives, what aspects of care did they particularly seek out and value? Bortin et al. (1994) indicated that the concept of midwifery care is one significant area deserving investigation and suggested the relationship between the midwife and the birthing woman as one possible focus. They argued that qualitative exploration, focusing on women's experiences, their feelings and values, would be particularly beneficial and offer new insights into women's needs and expectations at the time of childbirth.

For the present study a phenomenological approach was selected, as it was felt that this methodology would offer much more in-depth information concerning the kind of care that midwives provide that women experience as important and helpful, or unimportant and not helpful, during the antepartum, intrapartum, and postpartum periods. This approach does not try to impose predetermined categories upon women's experiences, but rather the researcher must collaborate actively with participants in developing knowledge that is both relevant and meaningful to all involved (McCrea & Crute, 1991).

## CHAPTER 3

### Methodology and Methods

#### Phenomenology as a Research Methodology

Phenomenology, the science of phenomena, can be described as a philosophy, an approach, and a research method (Oiler, 1982; Omery, 1983; Ray, 1994). As a research methodology, its purpose is to explore the humanness of a being in the world; it strives to identify, interpret, and understand the essential meaning of lived experience (the ordinary way in which human beings perceive reality; Bergum, 1989; Oiler, 1982; Ray, 1994; Streubert & Carpenter, 1995). It is a method of direct inquiry in which questioning by the researcher provides further insights into the lived experience of the "subjects" (often referred to as co-participants or collaborators). The researcher probes deeply into the essence of a selected phenomenon, going beyond the taken-for-granted aspects of life to uncover meaning in everyday practice (Bergum, 1989; Morse, 1992; Ray, 1994). Merleau-Ponty (1956) stated that "the whole effort of phenomenology is to describe experience as it is and to describe it directly, without considering . . . causal explanations" (p. 59). "It is the uniqueness of living that is vital, that makes our lives ours, and that is sought in phenomenological expression" (Morse, 1992, p. 91).

There are a number of core principles and concepts that are essential to an understanding of the phenomenological methodology. A fundamental concept is that of the "lifeworld" (Lebenswelt) or the world of lived experience (M. Cohen

& Omery, 1994). If the aim of phenomenology is to understand and explore the meaning of everyday experience from the perspective of those who are experiencing it, then it is essential that research begin in the lifeworld. This world of immediate, everyday experience is not easily accessible. We often take so much for granted that we fail to notice or really see all that surrounds us. However to see what is commonplace, to explore taken-for-granted aspects of life, is a task central to phenomenological research (M. Cohen & Omery, 1994).

Another key concept, stemming from the work of early philosophers such as Brentano and Husserl, is that of intentionality of consciousness or awareness (M. Cohen & Omery, 1994; Streubert & Carpenter, 1995). The basic structure of consciousness is intentional; consciousness is in the world and is always intentional (i.e., always 'consciousness of' something; M. Cohen & Omery, 1994; Streubert & Carpenter, 1995). We are not, however, reflexively aware of our intentional relation to the world. It is only in retrospect that intentionality becomes available to consciousness as we reflect on our experiences. Thus, it is only through the study of experience that consciousness will be revealed. Phenomenology then, becomes the research tool which can "uncover and describe the fundamental structures of our lifeworld" (M. Cohen & Omery, 1994, p. 139).

Perception, or original awareness, is what gives one access to experience in the world (Munhall & Boyd, 1993). The process of recovering this original awareness is referred to as reduction, a third principle of critical importance to the phenomenological method. Reduction is a particular manner of rigorous reflection and involves a suspension of belief as to the existence or nonexistence of the content of an experience. The researcher attempts to

awaken a profound sense of amazement and wonder at the mysteriousness of belief in the world (M. Cohen & Omery, 1994; Kvale, 1983; Munhall & Boyd, 1993; Streubert & Carpenter, 1995). The researcher must give absolute attention to the phenomenon as it is lived by those experiencing it, while setting aside his/her own subjective feelings, previous experiences, presuppositions, theoretical knowledge, and scientific conceptions. This process is referred to as bracketing (Munhall & Boyd, 1993; Oiler, 1982; Ray, 1994; Streubert & Carpenter, 1995).

Bracketing, the main methodological technique used to accomplish phenomenological reduction, does not mean that the researcher tries to forget, deny, or ignore what is already known. Indeed, Merleau-Ponty (1962) indicated that total reduction is, in fact, impossible. Instead the researcher attempts to become fully aware of his/her presuppositions and assumptions, and the existing body of scientific knowledge concerning the experience under investigation, which may predispose him/her to interpret the nature of the phenomenon before it has been fully explored. This knowledge is then set aside, or bracketed, so the researcher can focus full attention on the phenomenon as it appears. The researcher assumes an attitude of doubt, questioning taken-for-granted knowledge, and attempts to discover the true form of the things themselves (Bergum, 1989; Munhall & Boyd, 1993; Ray, 1994). The technique of bracketing is extremely difficult, however it is within human capability. Although total reduction is impossible, the human science researcher must work at it as vigorously as possible (Munhall & Boyd, 1993).

It is evident from the discussion of the above concepts that, in phenomenological research, all data are accepted as given. Data are not limited

to empirical facts or observable events. They include all available phenomena, such as subjective meanings, and the thoughts and feelings of participants (Omery, 1983). There are many data sources that the researcher can use in the search for essential meanings, for example, interview data, observations, literary works, poetry, and personal experience (Oiler, 1982).

### **van Manen's Interpretation of Phenomenological Methods**

van Manen introduced and explained a hermeneutic-phenomenologic approach, grounded in Dutch and German philosophic traditions, which emphasizes the interrelationship between phenomenology, hermeneutics (concerned with the interpretation of experience), and semiotics (the study of texts or signs; Ray, 1994). When explaining the methodical structure of hermeneutic phenomenological research, van Manen (1990) proposed that research activities involve a dynamic interplay of six methodological themes: turning to a phenomenon of interest, investigating experience as it is lived, reflecting on essential themes, describing the phenomenon through the art of writing, maintaining a strong and oriented relation to the phenomenon, and balancing the research context by considering parts and whole.

The starting point of phenomenological research is when the researcher chooses a phenomenon of interest, a phenomenon which concerns some aspect of human existence. van Manen (1990) described this as "turning to the nature of lived experience" (p. 31). The researcher must be committed to the study of the chosen phenomenon, such that he/she is "given-over" to the quest of exploring and understanding that phenomenon. This methodological theme

involves three procedural activities: orienting to the phenomenon, formulating the phenomenological question, and explicating assumptions and pre-understandings (van Manen, 1984, 1990).

Once the researcher has identified a phenomenon of interest, he/she then turns to investigating that phenomenon as it is experienced. Phenomenological research aims to establish renewed contact with original experience; the researcher re-learns how to look at the world by actively exploring the chosen phenomenon in all its modalities and aspects. The researcher thoroughly examines various kinds of material which might eventually offer the possibility of a deeper understanding of the nature of the phenomenon (e.g., etymological sources, idiomatic phrases, art, the experiential descriptions of others; van Manen, 1984, 1990).

The third research activity involves reflecting on the essential themes or "the experiential structures" (van Manen, 1990, p. 79) that characterize the phenomenon to try and identify essential meaning. When the researcher reflects on the lived experience under study, he/she attempts to establish what it is that gives this particular experience its special significance; what makes the experience what it is. In order to arrive at this understanding, the researcher must conduct a thematic analysis to uncover the essential themes in the data. These themes give shape to and describe the content of the experience. It must be kept in mind, however, that themes never completely capture the deep meaning of an experience. They are "at best a simplification . . . an inadequate summary of the notion" (van Manen, 1990, p. 87).

van Manen (1990) outlined three approaches to uncovering the thematic aspects in a text: (a) a wholistic or sententious approach (i.e., attending to the



text as a whole), (b) a selective or highlighting approach ( i.e., attending to particularly revealing statements in the text), and (c) the detailed or line-by-line approach (i.e., examining every sentence or sentence cluster). Following theme identification, the researcher and the participants should discuss and reflect on the themes to verify that they do indeed capture what the experience was like for each participant. This can lead to deeper insights and understanding for both the researcher and participants. This process can also be repeated with other researchers experienced in phenomenology.

Once essential themes have been identified, the researcher must describe the phenomenon through the act of writing and rewriting. van Manen (1990) argued that, to do research in a phenomenological sense, is always "a bringing to speech of something" (p. 32). In order to capture the essence of the experience in writing, the researcher must be sensitive to the subtle undertones of language, be a true listener and able to listen to the way the things of the world speak, and then use language to allow these things themselves to speak to the reader.

The fifth activity requires that the human science researcher maintain a strong and oriented relation to the phenomenon of interest. While conducting the research, there may be temptations to get side-tracked or to settle for preconceived ideas and opinions. The researcher must resist settling for superficialities, and instead remain strongly focused on the fundamental question or issue at hand (van Manen, 1990).

Finally, the researcher must balance the research context by considering both parts and whole. In conducting phenomenological research, there is a danger that the researcher may get so caught up in the writing that he/she loses

sight of the main goal: "to construct a text which . . . aims at a certain effect" (van Manen, 1990, p. 33). At intervals, it is necessary for the researcher to step back and look at the total design, to weigh the significance of the parts against the overall textual structure.

Although the six research activities have been listed and discussed separately, this does not mean that the researcher should complete each step one by one. In the actual research process, various activities may be undertaken intermittently or simultaneously (van Manen, 1990).

## **Methods**

The phenomenological research approach as outlined by van Manen (1990) was used to guide the researcher in conducting the investigation into women's experiences with midwifery support during pregnancy, birth, and the postpartum. This section includes a detailed description of the methods used for this particular study, as well as a discussion of the model of midwifery support under study, ethical concerns, and issues of credibility.

**Selection of participants.** The participants in this study were women who had been supported throughout pregnancy, labor, delivery, and the postpartum period by a nurse-midwife. There was no limit imposed on the amount of time since they had given birth as research has indicated that women have a vivid, long-lasting memory for many birth events (Bennett, 1985; Simkin, 1991, 1992a; Yarrow, 1982, 1992). Participants were chosen on the basis of the following inclusion criteria: they must (a) be able to speak, read, and understand

English, (b) be mentally competent, (c) be able to verbalize their thoughts, feelings, and emotions, (d) live within 100 km (approximately one hour's drive) of the city of St. John's, and (e) be over 18 years of age. The aim was to include approximately 10 (or fewer) women in the study. In phenomenological research, this number constitutes an appropriate sample size because the interview technique used yields extremely large amounts of narrative data for analysis (Munhall & Boyd, 1993; Ray, 1994).

A nurse-midwife, who agreed to act as an intermediary, was initially contacted in person to identify women who she had supported through pregnancy and birth, and who met the inclusion criteria for the study. This was followed up by a written letter of request (see Appendix A). She then contacted potential participants to determine if they were willing to participate in the study. A total of 6 women agreed to participate and their names and phone numbers were released to the researcher. The researcher then telephoned each of these women and informed them of the nature of the study (see Appendix B for telephone guide). One additional participant was obtained at a public meeting held by a local midwifery consumer group. The woman had heard about the study through a mutual acquaintance, approached the researcher after the meeting, and expressed interest in participating in the study. A final participant heard about the study through a friend who was already a participant in the research. She then obtained the researcher's number from her friend, and contacted the researcher by phone to ask if she could also be included in the study. A convenient time was chosen for the researcher to meet with each participant, obtain written consent, and conduct the first interview.

**The interview approach.** The interview is an important technique in phenomenological research. It is used to gather from the interviewees, rich, detailed descriptions of their lifeworlds, as the interviewer seeks to discover and understand the interviewee's experience of a particular phenomenon (Kvale, 1983; Mackey & Stepan, 1994). Unstructured, formal interviews were used as the main data collection technique for this study. This is an appropriate method of data collection in phenomenological research as specific research questions are not predetermined, and the researcher and participant can engage in an unstructured discussion (sometimes referred to as a conversation) in an attempt to illuminate the meaning of the experience (Bergum, 1989; Murhall & Boyd, 1993; Ray, 1994). As a supplement to participant interviews, the researcher also used various texts and articles (e.g., personal narratives) as data sources. Use of this material enhanced the researcher's understanding of the phenomenon under investigation.

In addition to the discussion with participants, the researcher also observed nonverbal behavior during the interviews, and took occasional notes as necessary. These notes contained reminders of nonverbal cues, recordings of interruptions, and ideas regarding possible emerging themes. Prior to commencing the interviews, a demographic sheet was completed on each participant (see Appendix C). This information was used to provide a brief description of each participant and is included in chapter 4.

Participants were requested to select a setting for the interviews which would be most convenient and comfortable for them. Seven women chose to be interviewed in their own homes, and one participant elected to meet at the researcher's home. Prior to each interview, the researcher attempted to bracket

her experiential knowledge in order to be more open to the reality and experiences as presented by the participants (Beck, 1992). Initial interviews lasted between 40-90 minutes and all interviews were audiotaped. Each interview began with a request to the participant to describe her experience with midwifery support as fully as possible. An interview format had been developed in the earlier stages of the research project (see Appendix D). This guide included a few open-ended questions to be used as prompts or clarifiers if needed. However, the researcher's questions and the flow of the interviews were largely directed by the participants' responses. Occasionally, prompts such as "Can you tell me more about that?", or "Is there anything else you would like to tell me?" were used to encourage participants to expand on their ideas and share more of their experience. When verbal and/or nonverbal cues indicated that participants had completed their descriptions or were becoming tired, the interviews were brought to a close.

Participants were contacted for a second interview approximately 2-4 weeks after the first. During this time period, the researcher had transcribed their interviews and completed a preliminary analysis of the data. A small number of potential themes had been identified and noted. All participants agreed to a second interview, seven of which took place in their homes and one in the researcher's home. Second interviews lasted between 30-100 minutes. Participants were given time to read and respond to the transcript of their initial interview. This follow-up interview was necessary in order to allow participants to verify that the interview data accurately captured their experiences, to clarify inaccurate or misleading information, and to further explore areas that may have

been omitted or discussed only briefly in the initial interview (Streubert & Carpenter, 1995).

**Data analysis.** Upon the completion of each interview, the tapes were transcribed verbatim by the researcher. Each interview transcript and any written notes taken during the interview were assigned an identifying code (to eliminate the need to use the participant's name). The transcription process encouraged the researcher to become deeply involved with the data, and to think about what participants were saying, as well as how they were saying it. Next, the researcher engaged in a process of reflection, and each transcript was read and reread, often while simultaneously listening to the corresponding audiotape. This ensured that tapes had been transcribed accurately, but also allowed the researcher to more clearly grasp the meaning of each participant's experience and to identify potential themes. It also prompted additional questions for subsequent interviews.

Throughout this process, the researcher also kept a personal log. Notes were jotted in this log following the completion of interviews, during tape transcription, and while reading transcribed interviews. This log included notes regarding the interview process itself (e.g., distractions or interruptions), notes critiquing the interview style, identification of interviewer influence on the interview process, tentative emerging themes, and areas which would need clarification in a second interview. This log helped the researcher become more aware of her own biases and encouraged a reflective and meditative attitude, thus aiding in the process of phenomenological reduction (Streubert & Carpenter, 1995).

The specific technique used in this study to uncover the thematic aspects of the phenomenon under investigation was the selective or highlighting approach as outlined by van Manen (1990). The researcher listened to the audiotapes and read each text several times, searching for phrases or statements which seemed particularly essential or meaningful in explaining the phenomenon of midwifery support during pregnancy and childbirth. These essential phrases and statements were highlighted. The researcher then examined each of these phrases / statements and attempted to capture, as succinctly as possible, the meaning conveyed. It was important that the researcher capture meaning, and avoid imposing conceptual abstractions or generalizations on the data. As well, it was important to distinguish essential themes from those only incidentally related to the phenomenon under study. The next step was to compare and contrast the themes obtained from each interview, to allow commonalities and differences to become apparent. Finally, the researcher identified overall themes which best described the women's experiences with midwifery support.

Once the essential themes had been identified, the researcher began the process of writing. Each section on the themes was written and rewritten until the researcher felt that she had captured, as adequately as possible, the significance between parts (the themes) and the whole (relationship among themes), thus providing insight into women's experiences with midwifery support during pregnancy and childbirth.

At various points throughout the data analysis process, the researcher sought collaboration with the participants and with others who were experienced in the phenomenological method. After the completion of each set of two or three

interviews and following the preliminary identification of themes, the researcher met with her thesis supervisor to discuss the progress that had been made and to review the themes that had been selected. Identified themes were refined and areas requiring more investigation were noted. The researcher also met with the members of her thesis committee, all of whom are faculty at Memorial University School of Nursing. Themes were presented and discussed, allowing the researcher to gain further insights and a deeper understanding of participants' experiences. These meetings also provided the opportunity for themes to be refined and validated.

Following initial meetings with the thesis supervisor, the researcher arranged the second interview with participants. These interviews were transcribed in the same manner as the first, and the selective reading approach was once again used to identify themes. No new themes emerged at this time, however the second interview did further the researcher's understanding of the experience, and assisted in clarifying information obtained from initial interviews. A third, telephone interview with 3 of the participants was conducted following extensive collaboration with the thesis supervisor and one meeting with the thesis committee. All themes had been identified, elaborated, written and rewritten several times. Copies of these written drafts were mailed to the 3 participants, 2-4 weeks prior to the phone interview. This third interview allowed these participants to become co-researchers in the process, as they assisted the researcher to validate themes and more accurately capture their lived experience.



**Ethical considerations.** When conducting phenomenological investigations, as with any research, there are a number of ethical considerations to which the researcher must attend. Prior to commencing this study, permission was sought and granted from the Human Investigation Committee, Memorial University of Newfoundland (see Appendix E). All participants were initially contacted or informed of the research (as in the case of the two participants who heard about the research from friends) by an individual who was familiar to them and who was not involved in conducting the research. When the researcher telephoned those women who had agreed to participate to further explain the details of the study, the women were reminded that they could change their mind and withdraw at any time.

Prior to commencing initial interviews, all women were required to sign a written consent (see Appendix F). This consent was thoroughly reviewed with each woman and a witness, and an opportunity was provided for the woman to ask questions and receive clarification. Participants were provided with a copy of the consent, including the researcher's name and phone number. They were advised that they could contact the researcher at any time during the study if they had any questions or concerns. It was also stressed that initial consent did not prevent the woman from withdrawing from the study at any future time.

Initial and subsequent interviews were scheduled at a time and place convenient for the participants. Participants were advised of the lengthy nature of the interviews and told they could take a break during the interview, stop and reschedule an interview, or refuse to respond to questions posed by the researcher that they would prefer not to answer.

The researcher took all reasonable precautions to protect the anonymity of participants and the confidentiality of information. All taped and transcribed data identified the participants by a code number only. All identifying information (e.g., consent forms, demographic sheets) were kept in a locked filing cabinet in the researcher's home. All identifying, written information was shredded upon completion of the study, and audiotapes were erased once the data had been transcribed and preliminary themes identified. Participants were advised that the completed study would be available in the Health Science Library, and that portions of the research thesis may be published. They were then given the opportunity to select pseudonyms (or use their real names if desired) that the researcher could use when providing examples of personal experiences in the written text. Three participants elected to use a pseudonym (indicated by an asterisk \* in the text).

Prior to conducting the actual study, the researcher had identified potential risks and benefits for participants. One concern was that if a woman had experienced a difficult labor or delivery, or experienced feelings of failure regarding her performance during childbirth, discussion of the event during the interviews may cause the woman to become upset. However, a review of relevant literature indicated that, on the whole, women welcome the opportunity to talk about and relive their birth experiences (Bluff & Holloway, 1994; McKay & Barrows, 1992; Simkin, 1991, 1992a; Yarrow, 1982). This discussion can actually be therapeutic, particularly so when the actual experience of labor and birth differed from expectations (Bluff & Holloway, 1994; DiMatteo et al., 1993).

**Credibility of findings.** Qualitative research should not be evaluated against the same criteria of reliability and validity as is used for quantitative research. Instead, qualitative research has its own criteria for precision. Sandelowski (1986) suggested that qualitative inquiry should be evaluated by examination of the credibility, fittingness, auditability, and confirmability of findings. This section will address the attempts made by the researcher to ensure the credibility of findings in this study.

In an effort to limit potential bias, the researcher reviewed relevant literature and identified her own perspective, and then made use of the technique of bracketing prior to data collection and analysis (Beck 1992, 1994; Oiler, 1982). Keeping a log throughout this process also helped the researcher become more aware of biases and preconceived assumptions (Krefting, 1991).

A qualitative study can be deemed credible when the descriptions presented by the researcher are such that the people who have had the experience can immediately recognize it as their own (Oiler, 1982; Yonge & Stewin, 1988). This "member check" or "subject validation" has been suggested by a number of authors familiar with qualitative research (Brink, 1989; Hoffart, 1991; Krefting, 1991; Lederman, 1991; Sandelowski, 1986; Streubert & Carpenter, 1995). To help ensure credibility (truth value) of the data in this study, the women were asked to review the transcribed copy of their initial interview to validate that the researcher had accurately captured their lived experience. Information obtained in second interviews was noted to corroborate information from the first. In addition, 3 participants were asked to examine the emerging themes. They responded with comments such as "it was like my own voice everywhere," "it was a very emotional read and I wouldn't change a thing,"

and "as I read through I couldn't remember what I said, but it didn't matter. So much of it spoke to me." This confirmed the researcher's interpretations.

Another method of increasing credibility and auditability (consistency) is to have another impartial researcher, experienced in qualitative research, read the interview transcripts and independently identify themes. This researcher can also critique the work done by the primary investigator. This has sometimes been referred to as "peer examination" (Beck, 1994; Jensen, 1989; Krefting, 1991; Sandelowski, 1986). In the present study, both the thesis supervisor and the thesis committee had an opportunity to review interview transcripts, discuss emerging themes, and critique the researcher's findings. Questions posed by these individuals contributed to further insight and a deeper analysis by the primary researcher. To further ensure auditability, the researcher has carefully documented the entire research process so that others would be able to follow the thinking, decisions, and methods used throughout the study (Sandelowski, 1986; Yonge & Stewin, 1988).

In order to address the issue of fittingness (applicability) of the findings, the researcher initially sought out participants who not only had experienced the phenomenon under study, but who were also able to clearly articulate their experiences (Beck, 1992). Fittingness was also enhanced by providing thick, rich slices of data, such as numerous direct quotes from participants, in the discussion of the findings (Jensen, 1989; Krefting, 1991; Rosenbaum, 1988). van Manen (1990) indicated that human science research "strives for precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection the fundamental nature of the notion being addressed in the text" (p. 17).

Confirmability (neutrality) was achieved by ensuring that fittingness, credibility, and auditability were established, and by attempting to ensure that researcher bias did not influence the results of the investigation (Beck, 1994; Krefting, 1991; Sandelowski, 1986).

**Model of midwifery support during pregnancy and childbirth.** All the participants involved in the research had been cared for by the same midwife in St. John's, Newfoundland, where the full scope of practice of midwifery has not been legalized. The services of this midwife were not advertised, rather the women heard about the service from friends, acquaintances, family doctors, or knew the midwife herself personally. Following the initial request for care, the midwife scheduled one early visit. This meeting allowed the midwife and client to get to know one another, permitted the midwife to describe and explain the range of her services, and offered the client an opportunity to discuss her needs and describe the kind of care she felt she required. Then, depending on the needs of the client, the midwife scheduled further meetings. Clients varied in the need for support, but in the majority of cases, the visits recommenced approximately 6 weeks before the due date, and involved four to six meetings. The woman was encouraged to attend the hospital prenatal classes in addition to the midwife's antenatal visits. The family physician or obstetrician provided routine antenatal assessments.

The antenatal visits were conducted in the woman's home, or in the midwife's home, whatever was most convenient for the client. The main aim of these meetings was to try and develop, within the woman, as many resources as possible so that she was able to approach labor with the confidence that she

would attain a satisfactory birth experience. The woman was encouraged to discuss her fears and concerns regarding the birth, and information on specific issues was provided. If the woman was multiparous, the previous birth experience was explored, especially if the woman had been traumatized by her experience. From this discussion, specific incidents which caused distress were identified and explanations and reassurance given. In addition, the midwife explored the woman's support system, for example, the role the partner wished to play in the birth was examined, and a birth plan was developed. The woman was taught the techniques involved in the psychoprophylaxis method of childbirth, such as conscious controlled relaxation and various breathing exercises. The midwife also provided education and a realistic appraisal of the labor and delivery process. Potential interventions were discussed but not over-emphasized. If necessary, education was also provided concerning nutrition and lifestyle patterns. Breastfeeding was encouraged by outlining the advantages to mother and baby. The midwife performed abdominal palpation to determine the size and position of the fetus, however no other formal physical assessments were performed, unless there were indications that this might be necessary (e.g., physical signs and symptoms of pregnancy-induced hypertension would necessitate a blood pressure check). The midwife was also available for telephone consultation at any point throughout the pregnancy.

Once labor commenced, the woman was encouraged to contact the midwife who met her at the hospital or visited her at home, depending on the circumstances. Home laboring support involved encouragement in the use of breathing and relaxation techniques, internal examinations, auscultation of the fetal heart by fetoscope, and provision of physical comfort measures. The

decision to move into the hospital depended upon the progress of the labor and the needs of the couple. Once into the hospital, the midwife assumed the role of patient advocate, while continuing to provide physical and emotional support and comfort, encouragement and coaching (e.g., with breathing exercises, bearing down technique), and appropriate education to meet the informational needs of the couple (e.g., regarding progress, any proposed interventions). She did not conduct physical assessments other than, on occasion, fetal monitoring, and did not conduct the delivery. The midwife's main aim at this time was to bolster the woman's natural strengths and resources so as to assist her in achieving her goals and objectives. If a cesarean delivery became necessary the midwife remained with the woman and her partner, offering support and explanation. Women who chose to do so, were assisted with breastfeeding as soon as possible during the fourth stage of labor.

During the postpartum period, the follow-up provided depended upon the time of the mother's discharge from hospital. If the woman elected to take early discharge (i.e., within hours of the birth), the midwife visited once or twice a day for 4 to 5 days, and conducted complete postpartum assessments. If the woman was hospitalized for the usual 2 to 3 days, the midwife visited at least once within 1 to 2 days of the birth and then, based on a mutual assessment of the mother's needs, decided whether or not subsequent visits were necessary. For these mothers, the complete postpartum assessments were not usually part of the care, as these had been completed in the hospital.

Postpartum care included a birth review, in which the midwife ensured that the mother understood what had happened during the birth and why things went the way they did, and any feelings of failure were identified and explored.

Regardless of outcome, the woman's accomplishments were emphasized, in an effort to enhance confidence and self-esteem. Assistance was given with breastfeeding, and the midwife addressed any questions or concerns the new parents might have. Once again, the midwife was available for telephone consultation during the postpartum period (K. Matthews, personal communication, November 2, 1995).

Apart from the support provided by this nurse-midwife, one participant did have contact with several other midwives in England during her pregnancy. She had thought she would be living there at the time of delivery and had begun to arrange for antenatal and intrapartum care. However, she returned to Newfoundland during her pregnancy and was cared for by a midwife here. Another participant had been attended by two other midwives for one of her birth experiences. This participant had lived in the United States at the time, where midwifery was legalized. The two midwives had shared antenatal care, one had provided intrapartum care, and the other, postpartum care. Their services incorporated the full scope of midwifery practice: for example, they provided scheduled antenatal assessments similar to a general practitioner or obstetrician, were able to conduct deliveries, and had admitting and discharge privileges to hospitals.



## **CHAPTER 4**

### **Findings: Toward an Understanding of Women's Experiences with Midwifery Support**

What is it like to be supported by a midwife throughout pregnancy, labor, birth, and the postpartum? How did the women in this study experience midwifery support? This chapter is an exploration of these women's experiences with their midwife.

The chapter is divided into four parts. The first part is a description of the women and relevant details of the birth for which the midwife was present. The second part is a discussion of the essential themes, supported by quotes and other pertinent information from the interview data. The themes, in no particular order of importance, are (a) midwife as ideal mother, (b) midwife as buffer: ensuring an optimum birth experience, (c) continuity in the midst of fragmentation: the midwife as a known constant, (d) presencing, (e) intuitive knowing, (f) seeking safe passage through the expertise of the midwife, (g) seeing the whole: the woman as part of a family, (h) maintaining control while letting go, and (i) midwife as trusted and trusting.

In the third section of this chapter, the relationship among the themes is examined. The various themes are not unrelated or isolated parts of a phenomenon. Instead they connect together to form a whole, and thus capture more completely, the women's experiences with their midwife. The final section explores "the essence"--what it was that gave meaning to these women's experiences.

### **The Women Who Participated**

The participants ranged in age from 31 to 42 years. Three were primiparas and five were multiparas. The following paragraphs offer a brief description of each participant.

The first participant had two children. Although she had received midwifery support during her first pregnancy, labor onset occurred approximately 2½ weeks early, and her midwife was away at the time. She did, however, receive midwifery care throughout the antepartum, intrapartum, and postpartum periods for her second child. Both labors resulted in spontaneous vaginal deliveries. The last delivery had occurred 27 months prior to the initial research interview.

The second participant had one child, born 9 months prior to the initial research interview. Midwifery care had been provided throughout the pregnancy, labor, delivery, and postpartum. This participant had labored for approximately three hours, but subsequently needed a cesarean birth due to a maternal, medical condition.

The third participant had two children, and had been cared for by a midwife during both pregnancies, labors, deliveries, and postpartum periods. Her youngest child was 4½ months old at the time of the initial research interview. This participant had experienced two spontaneous vaginal deliveries.

The fourth participant had two children of her own, plus an older step-son. The youngest child was a little over five years old at the time of the initial interview. This participant had received midwifery care during both pregnancies, labors, and deliveries, but unfortunately, the midwife was scheduled to leave

town immediately following both deliveries and so was not available for postnatal care. Both births were spontaneous vaginal deliveries.

The fifth participant had only one child and for that pregnancy, she had been cared for by a midwife throughout the antepartum, intrapartum, and postpartum periods. The birth, a vacuum-assisted delivery, had occurred 9.5 months prior to the time of the initial interview.

The sixth participant had two children, the first had been born by emergency cesarean delivery following a period of labor, and the second was a vaginal birth after cesarean (VBAC), aided by forceps. She had been attended by a midwife only for the second pregnancy, and the midwife had provided antepartum, intrapartum, and postpartum care. It had been 4.2 years since the birth of her last child at the time of the initial interview.

The seventh participant had two children, the youngest being 10 weeks old at the time of the first interview. She had initially lived in the United States and had been attended by two midwives for the first pregnancy. During the second pregnancy, she was cared for by a midwife in Newfoundland. In both cases, the midwives provided antepartum, intrapartum, and postpartum care. The first labor had ended in a vacuum-assisted birth, and the second, a spontaneous vaginal delivery.

The final participant had one child, born by spontaneous vaginal delivery 2 years and 10 months prior to the time of the initial interview. The midwife had provided antepartum, intrapartum, and postpartum care for this birth experience.

## Thematic Analysis

**Midwife as ideal mother.** One of the first themes identified was that of the midwife as an ideal mother. Seven of the 8 participants spontaneously referred to their midwife or some aspect of her care as being mother-like or motherly. Particularly when asked to describe the relationship that existed between themselves and the midwife, participants often described a close and intimate connection and referred to the sense of a maternal-child association:

She's like a super Mom? You need a mother, you know. That's what she was like. I think that gave me the strength physically to do it.

I do remember she was there too, and she'd touch me physically and touch my leg, or rub my leg. And that meant a lot. Just that contact. It was sort of like a mother touching you when you were a kid?

The 1 participant who did not use the word "mother", spoke of her midwife as "a wonderful person" who was like "a long-lost friend." There was no doubt that, for these women, the relationship with the midwife extended far beyond the usual health care provider-patient relationship. A number of participants referred to the midwife becoming a "part of the family." Indeed the bond between them was such that the women came to view the midwife as one of the most important family members: the mother:

I wasn't just a patient. You know? I felt like I was more than just her patient, you know, or she wasn't the nurse and I wasn't the patient.

I feel very strongly that there's a relationship. . . . I'm not really sure how to describe it, but I did feel a real strong connection. . . . Oh there definitely is that personal feeling. Yeah. It's a

closer relationship than I do have with my own mother.

The word "mother" has been with us in forms very much like its present English-language form for at least six or seven thousand years. Historical linguists have reconstructed the Indo-European word for mother as *Mater-* (the hyphen indicating that the word ending, if any, is unknown). A mother is one who gives birth to or one who protects, as a mother. The word mother or mother-figure is often used as an affectionate address to refer to another woman who is regarded as a source of nurture and support. One who is motherly is like or characteristic of a mother in providing affection, care and love (Allen, 1990; Family Word Finder, 1975). Through the ages, the word "mother" has become a synonym for "all that is good" (Bernard, 1974, p. 5).

The pregnant woman, in some respects, can be said to exhibit certain child-like qualities, such as dependency and the need for nurturing. Pregnancy, childbirth, and even parenting, can represent new or unknown entities. For example, Kitzinger (1978) indicated that, no matter how much a woman wants a child, pregnancy does frequently involve "a feeling of being taken over by an unknown and even hostile stranger" (p. 99). The woman may feel quite vulnerable and anxious as she faces the challenges that lie ahead. For instance, several participants indicated that they viewed childbirth as a "scary" or "frightening" event. Chesler (1979) poignantly captured what is perhaps the ultimate fear when she stated "only a girl-child would still want her Mommy with her when she gives birth--or dies" (p. 82). Ella\*<sup>1</sup> explained

And it is such a *new* experience. I think everybody can feel quite child-like facing it for the first time--well, maybe every time. . . . You become incredibly vulnerable.

<sup>1</sup> \* indicates a pseudonym

As she prepares to become a mother, it is important for the woman to have someone to share in her experience, someone to care for her, to love and nurture her. Odent (1981) stated "women must engage themselves effectively to bring love and at the same time, to bring experience, as a mother would" (pp. 9-10). When questioned, participants admitted that a feeling of being mothered during pregnancy was important to them, and the midwife was seen as a special woman who provided this mothering to the mother-to-be during pregnancy and particularly during labor and delivery:

[Sarah\* was asked if feeling mothered had been important to her] Yes. It did actually. Yes. Especially having no family around. . . . That's what I wanted. . . . 'Cause I wasn't feeling at all confident or capable about anything at the time. (pause) Yes. We were very happy being mothered a bit.

Ideally it is one's own mother that a pregnant woman can turn to: to seek nurturing and support, to share experiences, to gain knowledge and understanding of pregnancy and birth. She is the one who should serve as the woman's strongest model (Rubin, 1984). However, 6 participants indicated that they were physically or emotionally distanced from their mother, their mother was unwell, or not particularly involved in or supportive of the pregnancy. So although the midwife assumed a motherly role, this was not just because she reminded participants of their own mother. Five participants specifically indicated that the midwife was not like their mother, and several participants went further to state that she was more supportive than their own mother or that they felt closer to the midwife than to their mother:

You might sort of feel too . . . you might think of your mother?  
Or she might have reminded you of your mother, or (pause).  
But she didn't.

I felt closer to [my midwife] than my own mother. It's as if she really cared.

Initially, a number of participants related the ability to mother to factors such as the midwife's age (i.e., the midwife being an older woman), her appearance (i.e., "she seemed like the right kind of motherly type for the job"), or the fact that she had given birth herself (i.e., being a mother). However, as they continued to discuss the concept of midwife as mother, they decided that although these factors could be assets, they were not essential. Lee\* noted

It wasn't just that [midwife] was a mother. She was a mother's age too and that, but the other midwife [for the previous pregnancy] was my age and I felt that way with her.

In addition, 2 participants pointed out that they did not view the midwife as simply "a nice little mother-figure" or someone who was "smarmy and sweet" with no understanding of limits. Nor did this characteristic of the midwife refer to mothering in the conventional sense, where the woman must follow certain rules or regulations set down by a parental figure or else risk punishment or disapproval:

I did feel that was important to me. But not mothered in what I think some people would consider mothering. Sort of the authoritarian traditional sense. Because that I could have easily gotten from a medical doctor and birthed within the medical establishment.

It became evident that the mothering theme was unique in its description and did not simply represent general perceptions of the traditional mother. Instead, participants spoke of their midwife as the ideal or replacement mother, the type of mother that one would select if it were possible to choose:

I think there's a certain sense of a maternal relationship there, and not that she's like my mother at all. But like the mother that you would want attending your birth.

For all except 1 of the participants, who had known her midwife for years as a friend, upon initial contact, the midwife was a complete stranger who had been recommended by friends or acquaintances. However, as these participants described the initial meeting with the midwife and the care she provided throughout the antenatal period, there was no sense of a sort of introductory period, where a tentative relationship began and took time to become established. Instead it seemed there was an instantaneous connection between the midwife and the client which permitted them to transcend interpersonal distances and overcome potential barriers very quickly. Participants spoke of immediately feeling "very close" to the midwife, "liking her instantly," or having a sense that they'd "always known her" or known "somebody like her." This perhaps is symbolic of the mother who immediately embraces her newborn infant, or the soon-to-be adoptive mother who loves her baby, sight unseen. Marie stated

It was just like we'd known her all our life. . . . There was a reassurance about her. And just an immediate compatibility. . . . I'd never met [midwife] before. . . . And you know, at that first meeting, I just felt automatically at ease with her.

When participants were asked to share their thoughts as to why they believed the relationship developed so quickly and so easily, some of the women initially found it difficult to explain. Five participants suggested that, in a way, a common bond existed between the woman and her midwife, even prior to the initial contact. Upon becoming pregnant, a woman yearns for a special



individual who will provide love and nurturing. Chesler (1979) questioned "who, then, will rejoice with me if not my mother? Suddenly I'm returned to my childhood, to my search for mothering" (p. 6). The midwife was that special individual, a health care provider who was chosen by the woman, rather than someone chosen for her, like the nurse assigned at the time of admission to hospital or an obstetrician to whom she is referred. Each participant anticipated that the midwife would be someone who would have a philosophy of birth similar to her own, someone who would not impose her own beliefs or some set of rules upon the woman. Like the ideal mother, the midwife would be truly interested in their welfare and that of the baby, and be there to help and care and assist the woman through the birth experience. It was as if they knew the midwife to some extent before they even met her. Janice commented

I mean, you know this person is going to help you, and you looked for her to ask for help and she's agreed to help you . . . why wouldn't you like her right away?

Marie suggested that perhaps the immediate connection was also due to the fact that the midwife was "so accustomed to meeting couples" and "really knows what they're going through." This implies that perhaps the midwife knows a little bit about each woman too, in a general sense, prior to the first meeting, much like the mother who has certain expectations of how her new infant will look or behave. In addition, 6 participants referred to the midwife's personality or some characteristic of her personality as a factor contributing to the development of an instantaneous rapport. The women indicated that the midwife was immediately perceived as being "open" and "understanding." She gave the

impression that she had time for them and was able to put them promptly "at ease." Lee\* explained

Well, she was very, very welcoming? And we went in there for an hour's chat, you know, and we asked her all sorts of questions and she just answered everything. . . . I just felt very comfortable with her. Right from the beginning.

As participants discussed the connection that existed between themselves and the midwife throughout the childbirth experience, they described a special and personal bond, a relationship that was very different than that established with other health care personnel. As we rely on our mothers to be there for us through most of our lives, the midwife was someone who the woman could depend on to be there for her during the antepartum, intrapartum, and postpartum periods. Like that ideal mother, it appeared to these women that the midwife was there only for them, their interests were uppermost, they were special. Similar to the mother who is sensitive to the toddler's need for independence, the midwife educated and informed, but then always respected and supported the woman's decisions. She helped the woman develop confidence in her own abilities but was always there to guide and protect when the need arose. The midwife strived to assist each woman to get what she wanted from the childbirth experience:

What I was looking for was somebody who would help me get what I wanted from that experience and I think that's what a real mother, in a lot of people's eyes, that's what a mother would do for you.

And it went beyond the realm of labor and delivery and midwifery. . . . I mean, we chatted about things like we were just two people. . . . Well, you're not just a pregnant person, you're a person.

"Traditionally the ideal of motherhood . . . has embodied concepts of tenderness, compassion, generosity, selflessness, love, harmony and creativity" (Kitzinger, 1978, p. 245). When discussing their midwife's mothering qualities, participants frequently used these adjectives. Participants described their midwife as being empathetic, respectful, reliable, trustworthy, nurturing, and honest. They spoke of the tenderness, the gentleness, and the understanding embedded in her care which engendered in them, a sense of safety and security. In addition, the women felt that she really listened to their concerns and was open to discussing even the most trivial of their worries:

They [midwives] mother (pause) because well, mothers will listen. Mothers listen to what their daughters tell them and what their problems are.

Being mothered was really just the support that I felt I had from her. She was very gentle and supportive and understanding.

Above all, there was a sense that the midwife's care and attention was given unconditionally. Participants felt safe to disclose personal aspects of self, share past experiences, make choices and decisions without fear of retaliation or judgment. They spoke of the midwife as someone they could "cry in front of" or "give a hug to", or even someone to whom they could "surrender" completely. They believed their midwife would continue to offer compassionate care even if they disagreed with her advice, or "completely lost it" during labor, and without them having to offer anything in return:

I felt like she took on a--there was a motherly part. . . . Well, she was in a way like a mother because she nurtured and she cared and she loved, you know. And it was unconditional. Really unconditional. She didn't expect--there was nothing I had to give her back. I just was there.

Participants viewed the birth itself as the event which really cemented the relationship. The fact that the midwife remained with the woman, guiding, coaching, and supporting her through such a deeply personal and challenging experience, heightened the feelings of attachment that the woman felt towards the midwife. One participant became very emotional as she described the bond she felt with her midwife following the birth of her two children:

Because I liked her and, you know, thought a lot of her before the experience, but then after that--you think this person is so key to my whole being and this child's being, and (becomes tearful).

This close and intimate relationship, which developed between the woman and her midwife throughout the pregnancy, was something that participants found very difficult to "let go of" when they no longer required the midwife's professional care. This is similar to the child who finds it difficult to leave home to pursue a job or post-secondary education or who feels a certain sadness when getting married, as these events signify a "breaking away" from the maternal-child relationship, a change from the way things have always been in the past. For all of the participants, the professional relationship between themselves and their midwife ended soon after the birth (when the midwife had to go out of town), or at some time during the postpartum period. Although the professional relationship had ended, most all of the participants recalled finding it very difficult to bring closure to the personal relationship that existed. Participants used phrases such as "but I missed [midwife] afterwards," "it [termination of the relationship] hurts coming down," and "you've lost that important person" as they attempted to describe their feelings during the puerperium:

I think I wasn't really ready for closure at that point. . . . It's like falling in love with somebody and then out of it again! (laughs)  
Then trying to break that and wean yourself off the relationship?

A number of the participants stated that they maintained contact with the midwife for a period of time after the birth, visiting her to give a gift of appreciation or going out for a meal. Two participants stated that they still continued a friendship with the midwife at the time of the interviews. Others made comments suggesting that when a chance meeting occurs between themselves and the midwife, the sense of connection is still strong. It was evident from their stories that the special relationship between the midwife and client extended far beyond the actual birth event:

And I remember for the longest time after, just feeling what a wonderful person--and I mean, I still do. I can run into her anywhere and we just chat like old friends, you know. I suppose there's not many people you can say that about. . . . I mean, I can go a whole year and not see her. And it's just like you saw her yesterday. So I feel that, you know, for whatever reason, we had that--we have that kind of relationship. It's just--you know--it's (pause). What do you say about somebody who helped you bear your children, you know? It's that kind of close feeling.

I mean, she'll always be part of my life because of having been involved in the pregnancy and the birth. There'll always be a connection.

**Midwife as buffer: Ensuring an optimum birth experience.** One predominant theme identified from the interviews was the participants' view of the midwife as a buffer, someone who, by functioning in this capacity, would assist each woman to attain an optimum birth experience. Rubin (1983) has described the "dissipation of body boundaries" experienced by the woman

during pregnancy and childbirth (p. 249). In response, the woman acts to protect herself by setting up "a protective 'buffer zone' . . . through the quiet, sustained presence of another person. . . . She uses other people as buffers, since she cannot recruit her own protective responses" (p. 249). A buffer, derived from the Old French "bufe" meaning a blow, refers to anything that lessens or serves to absorb shock, or which protects against or reduces the effect of an impact (Allen, 1990; Williams, 1980). A thesaurus suggests words such as shield, cushion, and protector as synonyms (Family Word Finder, 1975). Participants did, in fact, use these terms to refer to their midwife, in addition to the words "bridge," "back-up," "liaison," and "middleman."

In describing the physiological process of labor, it is quite plausible to view it as a type of "shock", an event which, in most cases, truly challenges a woman's physical and emotional capabilities. Rubin (1975) discussed the "stress and exhaustion of labor and delivery" and the massive physiological changes which occur in the immediate postpartum period, indicating that, for any other non-pregnant person, such changes would signal a need for immediate hospital admission, evaluation, and bed rest (p. 1684). Participants spoke of painful contractions and unfamiliar sensations, and portrayed the physical experience as being "traumatic," "frightening," "stressful," "incredible," and "awesome." In addition, the professionals who worked within the medical system were seen as having the potential to have a negative impact upon birth events. In the midst of all this was the midwife as buffer, an individual who participants believed could make the difference between a positive birth experience, one that the woman could feel good about, and a disastrous, demeaning, or disappointing birth experience:

I wanted it to be as natural as possible and I really think that with [midwife], that was the only way that I could do it.

I wanted to have the birth that I wanted, and I know I was more likely to have that with a midwife.

All participants were able to relate specific examples of how the midwife functioned in this buffering role. For all the women, the midwife acted as a buffer between themselves and the unknown. She was like a cushion, softening the impact of the physical and emotional challenges of childbirth. Throughout the antepartum and intrapartum periods, the midwife was able to demystify some of the unknowns for the woman by explaining the process of birth and what to expect. The midwife also educated the woman regarding techniques that could be used to help her cope more effectively with whatever challenges she might face. Because of the trusting relationship established with the midwife, and her constant presence through labor, participants came to view the midwife as someone who would somehow shepherd them along the journey and guide them in the use of the techniques they had learned. The midwife was seen as a sort of protector: someone who was able to offer the woman a sense of security and allay many of her anxieties. Janice explained

I think a lot of things, you can get through it if you know ahead of time psychologically you're prepared? And I was prepared. My mind-set was "She's here with me, nothing's going to happen that I can't handle." If I was on my own and feeling insecure and worried and the first bit of pain I'd say "Give me medicine!" . . . It would have been a totally different experience. . . . She helped me be sort of more prepared, just by, you know, saying "I'm there. If you need anything you can ask me." . . . "I'll help you get through it."

Participants also viewed their midwife as a shield or buffer between themselves (and their partners) and the "system" (i.e., medical staff, nurses, hospital policies and procedures). Several participants indicated that the mere physical presence of the midwife decreased the number of other staff who would ordinarily be required to be present. Some women commented that other professionals trusted and respected the midwife and so, as much as possible, left her alone to care for the client. This was exactly what the women wanted, as they saw birth as a personal and private event, and resented having "strangers" intrude on their experience. Participants also suggested that, having the midwife there, protected them from unpleasant or demeaning encounters with hospital personnel, or deterred these individuals from intervening with unwanted advice and suggestions:

What I was talking about with the physical buffer there as well was the fact that I didn't need as many medical personnel with me at the time. . . . I didn't need 2 or 3 nurses.

It's quite annoying the way some of the medical profession talk down to you. Having her there was just fantastic to know that there was someone to back me up.

The nurses had a completely different stance when they walked in the room and [my midwife] was there. . . . [They] never came in offering all sorts of advice . . . like they did with the first [birth].

The participants' view of the midwife as buffer did, however, extend beyond the idea of a mere physical shield. Similar to a lighthouse, the midwife was also able to guide the woman through the potentially turbulent waters of a hospital birth and protect her from unnecessary hazards. In fulfilling her role as an educator, the midwife kept the woman informed and encouraged her to participate in decision-making, thus preventing hospital staff from imposing



decisions or performing unnecessary, "routine" procedures without the woman being fully aware of the risks and benefits:

She kind of ran a liaison between me and the institution. I could talk through her to people I wanted to get through to. And that buffer--it felt really nice to have her there.

She's the liaison, sort of too. She's the middleman between me and the staff. . . . Knowing that I had her there to protect, to talk to . . . or tell me what's actually going on. That's a fear that I had--that people don't tell you what's actually going on. . . . It did make it a lot easier knowing that [midwife] would be there. . . . She would be there to stand up for me if I couldn't myself.

At times when it was difficult for the woman to speak for herself (i.e., because of pain or anxiety), there was a belief that the midwife would interact with staff to ensure her wants and needs were identified and respected. She was seen as a bridge between the woman's world--her thoughts, feelings, and desires--and the busy, clinical world of the rest of the health care team. The midwife was seen as a negotiator: She may not agree with everything that went on within the system, but was able to work well with those people who were part of the system to negotiate on behalf of the woman for the things she wanted and did not want in her birth:

I felt like I had a buffer between the medical system and myself . . . and I needed someone between me and them to get what I wanted.

If you feel like you have got somebody who can buffer that system for you, somebody who's able to work with those people and yet get what you want from the birth--that's what I needed at the time.

Participants believed that, by assuming this buffering role, the midwife was able to remove some of the stumbling blocks along the way so that the woman's progress through childbirth was facilitated. She also made it possible for the woman to attain her goal of achieving that optimum birth experience:

The whole thing just went more smoothly. If you took [midwife] out, I don't think it would have.

Throughout pregnancy, and perhaps particularly near the end of the third trimester when the challenge of labor looms near, each mother-to-be likely hopes and dreams of the perfect birth. What is ideal is an individual matter, as was evident from the participants' stories. Some women hoped for a natural childbirth without drugs or interventions, others were quite open to receiving medication in order to lessen the pain, and others desired only a safe outcome for mother and baby, whatever the route needed to achieve this. Each woman had a vision of how she would like labor to be and what her role would be in it. However participants were also aware that what "Nature" had planned might not be in their scripts. They spoke of the unknown quality of labor and delivery, even with repeat birth experiences. With each successive pregnancy the woman might know more about what to expect or do, but there was always an aspect of mystery: "What will it be like this time?" Participants were aware that the midwife could not guarantee them a perfect birth. However, through implementation of the buffering role, the midwife was seen as an assurance for an optimum birth, someone who would ensure the best possible compromise given the individual woman's situation:

Well, I first got interested in having a midwife partly because

my first child was delivered by cesarean, and it had been an emergency section. With the second one I was very much interested in doing a vaginal birth after--so a VBAC, as they call it. . . . And so I thought it might be (pause) helpful in trying to have a VBAC . . . and thought "Well, if I had somebody to help me with that, it might help the process."

She couldn't say to me "Everything's going to go perfect and you're going to have a healthy baby." But I knew whatever was in her power in view of all I was going to have to face--like if the baby had had a problem, she would have still given me all the care that I would need, psychologically and physically. So that was the part. It was like she wasn't going to make it *perfect* but as long as I had her, I could handle anything. So that was the thing. Knowing you were getting the best job done in view of what you were working with.

When asked to describe the midwifery support received during labor and delivery, participants invariably discussed their birth experiences in great detail, weaving descriptions of their midwife's care and aspects of their experience together as one connected process. Some women recounted labors which progressed naturally, without drugs or other interventions, and which were fairly easy to cope with. Others outlined extremely long and tiresome journeys which ended in a forceps or vacuum assisted birth, while others described rapid and overwhelming excursions likened to a "train" charging down the track. Some women needed medication in order to cope with the pain. One participant required a cesarean delivery because of a maternal medical condition.

Regardless of the type of journey that each woman was required to make or the ultimate outcome of the labor, participants were always positive regarding their midwife's role in the birth and most likely were also able to describe positive aspects of the birth experience itself or of their own overall performance. If procedures and interventions did become necessary that were not part of the

woman's script for her ideal birth, the fact that she was aware and informed of, and most likely contributed to these decisions, prevented her from feeling victimized. The woman could still look back at the birth and view it as a positive experience overall. There was a sense that personal goals were accomplished. Participants seemed to have little need to recreate events looking for the "what-ifs". As Ella\* commented: "My second birth, it just--it fit. I wasn't constantly needing to go over it." It was as if the midwife was seen as a medium, a buffer between "what was possible" and "what actually was". She had assisted each woman to negotiate the best possible deal under the circumstances, whether or not this had been the woman's original notion of the ideal birth:

But I was so pleased that I managed the VBAC, that nothing else mattered to me. (Donna had received a narcotic for pain relief, and had a forceps delivery)

She made me feel like a million bucks. I was the hero of the drama. . . . After I'd given birth, I was very proud of my body. (Janet had an extremely long labor and had received a narcotic for pain relief)

It was the best thing ever. It really was. I couldn't have had a better birth. I really couldn't. (Sarah\* had a cesarean delivery following three hours of labor)

**Continuity in the midst of fragmentation: The midwife as a known constant.** Another theme which illustrated these women's experiences with midwifery care was the notion of the midwife as a known constant, one who represented continuity in the midst of fragmentation. A constant, from the Latin "constare", refers to "anything that does not vary", something that remains the same in all circumstances (Allen, 1990, p. 245). When applied to an individual, it suggests one who is devoted, dependable, and trustworthy, someone who will

be a stable companion, perhaps throughout a difficult journey. The participants in this research viewed their midwife as such a companion: someone who was known, someone who was committed to the process, and someone who would be with them throughout the childbirth experience.

Through their stories, the participants portrayed the childbirth experience, from the time of conception to the early days of parenting, as one of challenge, of change, of mystery. It is an experience which will take a woman beyond the limits of what she has known. She travels an unfamiliar path, knowing only that she has begun her journey as a woman, but will exit as a mother. There is the extinguishing of an earlier self, as this transformation from woman to mother is completed. As Denise proposed

And you really don't know where you're going. It's like you're on this--on this little--I don't know, you're on a journey. That's what it felt like, you're on a journey.

Participants indicated that even having previously completed such a journey does not ensure that a woman will be adequately prepared for a subsequent pregnancy. There is no road map guaranteeing that the route will be the same. The 5 participants who were multigravidae, spontaneously pointed out differences between their two pregnancies, labors, and births:

Even the second time, even having had a baby once and thinking you know what is going to happen, I mean, it was so different, even the second time.

With so many unknowns inherent in the process, the participants in this study stressed the idea that, to have an individual who was known to them, be with them for the entire childbirth experience, was absolutely crucial. The

companionship and attendance of this individual reinforced the woman's capacity to cope and offered some relief from the uncertainties and anxieties inherent in the birth journey. Participants spoke of the midwife as this constant, their "lifeline," someone with whom they had a "connection," someone they knew all along who also knew them:

I would want the midwife who I had seen before and I'd like to see the same person after birth. I think that's crucial to me. That's really what I was looking for when I went to see a midwife.

For me, what was most important was to have the same person, or a familiar person, who had seen me throughout the pregnancy, who got to know [husband] and I, and the kind of birth we wanted, be there for the birth of the baby. Just that continuation of care.

Participants explained that the relationship between the midwife and client was initiated during the antenatal period. All of the women spontaneously mentioned the prenatal visits, which in most cases, were conducted in either the midwife's or the client's own home. These visits, which occurred in an informal and relaxed setting, provided an opportunity, not only for the necessary monitoring and teaching, but also for the woman to get to know the professional who would be caring for her during childbirth. Many participants spoke of the personal and intimate atmosphere of these home visits, which often involved the sharing of a meal or snack. One participant described the midwife's antenatal visits as being like a pre-birth ritual, special occasions of close human contact and sharing, which helped prepare her for the actual birth event:

There was almost like a little ceremony involved? I really wanted to prepare this meal and enjoy the fire. They were just cozy winter visits. . . . It was a really nice way to get to know her.

Most all of the participants also discussed the importance of midwife self-disclosure during the antenatal period. When the midwife shared aspects of herself with the woman, it encouraged the development of the relationship in an open and trusting way. Participants remarked that, even with family doctors whom they had seen for a considerable period of time, they really knew "nothing about them" or what they might know would be "completely superficial." Marie explained

I *appreciated* her sharing information with us. . . . She really wasn't obligated to. . . . It helped the friendship develop . . . and a familiarity. . . . It helps you feel at ease with each other.

One participant, Janice, spoke at length about a friend who had birthed without a midwife for support. It seemed that one of the negatives which had stood out for this individual was the fact that one of the nurses caring for her wore a perfume which made her feel nauseated during labor. Janice concluded by stating that with her midwife, whom she had known throughout her pregnancy, there had been "no surprises" when she finally went into labor and needed someone to help her:

I knew everything. I knew her personality, and I knew she wasn't gonna [sic] freak, or you know, go home and have a smoke in between and come back.

For a number of the participants, their midwife was scheduled to leave town soon after their due dates. These women spoke of the anxiety created by the possibility of not having this familiar and trusted individual with them if they went overdue, or of being cared for by the midwife who had agreed to take over. Although this other midwife might have been quite competent, she was not

known by the client, and Donna likened this to "calling up a stranger and saying 'OK. I'm going to have a baby now'."

Not only did each participant feel that the midwife was known, but reciprocally, the woman herself was known by the midwife. The time spent together antenatally allowed for mutual sharing of information and permitted the midwife to come to know each client personally, as well as to identify her needs, hopes, and desires. So this was also part of the theme: the participants felt secure in the knowledge that their familiar companion also knew them, knew what they wanted and what might be best for them at times when they weren't able to make rational decisions themselves:

It's so wonderful because she knows exactly what you need. And she knows your personality. So that was great too. And you get to know each other.

I feel like she knows me and she knows if I should go to the hospital and (pause). She knows what my feelings are before I go into labor.

The care provided by the midwife extended throughout the antenatal period, and then, as participants pointed out, she also came to them early in the labor and stayed with them until after delivery and even beyond, into the early postpartum recovery period. At the time of labor onset, when the woman was anxious, apprehensive, and in pain--a climate hardly conducive to relationship building--the midwife was a known as opposed to a stranger, and participants received tremendous support from having this familiar and constant companion with them. They spoke of the sense of safety and security engendered by the midwife's constant presence, and how this gave them the confidence to carry on and endure. When pain, fear, or anxiety threatened to erode the woman's belief



in her ability to cope, or indeed, to survive, she was able to reach out and make contact with a familiar individual. There was always someone there to support her, someone to lean on, someone who would keep her from falling and from failing:

The fact that they're *there* with you through it, I think that was the thing . . . that she and [husband] were sharing that experience with me. There was never a moment when I felt them wandering away or just being distracted by anything else. It's like "We're here with you."

For all except 1 participant (when the midwife was scheduled to leave town), the midwife continued her care into the postpartum period, providing follow-up through hospital or home visits. Participants stressed the importance of these visits, and indicated that, having been safely guided through the birth by the midwife, they were now at times reluctant to take advice from anyone else:

It was interesting. Because I had [midwife] from the beginning to the end, I didn't really want anyone else. Like if I had any questions, I would call her.

And care starts there when she meets you and it doesn't end . . . even after you have a baby, it doesn't end. . . . There's still questions and some things are going to come up and you call and you know she's not far away.

It was evident from participants' stories that the midwife was likely to be the only link from pregnancy to labor and birth, through to the postpartum. When the women spoke of other health care providers, they portrayed a system of fragmented and often depersonalized care. The family doctor or obstetrician, though he/she may have followed the woman during her pregnancy, often did not appear until the late stage of labor and in one instance, arrived too late for

delivery. For several participants, their family doctor and obstetrician shared care, and the woman was passed from one health care provider to the other at a certain point during the pregnancy or postpartum. The 3 participants who were cared for by a specialist during their pregnancy were aware that there was no guarantee that their obstetrician would even be present if the delivery took place after hours or on a week-end. They found this uncertainty to be troubling and it contributed to their initial decision to involve a midwife:

My obstetrician worked at the hospital and he'd always said he might not be on call when I had [baby] and he wasn't, and I would have been just surrounded by nurses and doctors I didn't know, which would have been really frightening. Having [midwife] there was absolutely fantastic.

I really didn't like the set-up that you don't know who you're getting if you go into labor after 5 o'clock. . . . But the fact that I had the midwife gave me a great sense of relief though, because she would be there no matter who was on call. That was an important thing.

Compounding the discontinuity of care experienced with doctors was the fragmented care received from nurses during the intrapartum period. Three participants who had endured long labors recounted memories of several shifts of nurses changing while they were in the labor and delivery unit. For example, Lee\* recalled that there had been three different shifts of nurses involved in her first birth experience. In addition, participants indicated that the nurses often had other responsibilities: other patients to care for or other tasks to perform, and therefore could not be relied upon to be there with them all the time. Yet, as Rubin (1984) stated "attending persons who leave periodically or intermittently, no matter how available on call, increase the woman's tension" (p. 84). Fears intensify and panic occurs when the woman in labor feels isolated or

abandoned. Janet discussed the difference between midwifery and nursing care as follows:

I wouldn't say it would be impossible for a nurse to do what [midwife] did, but I doubt very much if--the way the hospitals work--they're on shifts and you know, you couldn't rely on that person having the personal attachment? I mean, she has other patients to see, other places to be (pause). So, pragmatically, it probably wouldn't turn out that way, even if you got the perfect nurse. She wouldn't be there or you couldn't depend on her being there when you needed her.

Meanwhile, the midwife was not influenced by the shift rotation system that nurses employed by the hospital had to follow. She was also not distracted by other tasks or other patients. She was committed only to the woman and her significant others, and provided continuous care throughout labor and delivery, no matter how long it took. Then, when the drama and excitement of the delivery was over and the doctor had gone, and the nurse might be assigned to a new client, the midwife was still there, assisting with breastfeeding, promoting bonding, and in some cases, providing physical care. Thus midwifery care was able to capture the totality of the woman's experience and transcend the fragmentation that the woman encountered with the traditional obstetrical health care system. For these participants, receiving midwifery support meant that they did not have to travel alone through the uncharted course of birth, nor would they have to switch guides just when the terrain was at its most treacherous. Denise explained

So it's like it's (pause) it's like the midwife guides you through the process of giving birth to a baby, but it's your own journey. Everyone's journey is different and that's OK. But if you got someone with you, that's connected with you, it makes a big difference. It means that you're not alone. And I think that's a

crucial part. You're not alone.

**Presencing.** A fourth theme evident in the interview data was that of presencing, the notion that the midwife represented a sustaining presence to the clients for whom she cared. This theme was most evident when participants discussed their labor and delivery experience, and was less important during the antenatal and postnatal periods. Childbirth can be an isolating and lonely experience for the woman who is going through it, as only she feels the pain and the strange, new sensations, and the process draws her increasingly inward, as she searches for hidden strengths and possibilities within herself. Chesler (1979) illustrated this concept clearly when she wrote about her labor experience: "*I am absolutely alone. I watch from above, recording this terrible break with reality*" (p. 116).

When a woman labors and births within the traditional hospital system, there are a number of people present who provide care at one time or another during the process, who potentially could alleviate some of this loneliness and be there for the woman. For instance, participants discussed the nurses who were present during their labors and the family doctors or obstetricians who delivered their babies. Sometimes their stories were positive, sometimes negative, and sometimes the participants indicated that they could remember very little about these individuals. It seemed that although these individuals were physically present, in most cases, the participants did not see their care as having had much impact upon the complex emotional experience of giving birth:

The nurses would go in and out and they were sort of there but not there.

'Cause it's kind of like, I know my doctor was there but I don't really? [with first birth] And again, I couldn't even tell you who

was in the room with me when I had her [second baby]. . . .  
They didn't mean anything to me. They didn't do anything for me.

When discussing the role that their midwife played in the birth, participants expressed the belief that the midwife was more than just physically present. Instead they suggested that she offered a special presence, and often spoke with a sense of awe and wonder about the support she had been able to provide during labor and delivery. Somehow the midwife was able to reach out and make genuine contact with the woman and enter into her world. Several participants even referred to a spiritual dimension of the midwife's presence. For instance, Denise spoke of the "spiritual connection" that she felt with her midwife during the birth process. Marie believed that when her midwife placed her hand upon the woman's abdomen, it was as if she could almost feel through the outer body and see what was going on inside:

I found with [midwife]--almost a kind of (pause) it might sound silly--a sort of spiritual dimension. I remember when she put her hand on my fundus, I sort of felt that she could almost feel through there and see what was going on.

Participants did not spontaneously speak much of the physical tasks carried out by the midwife during pregnancy, labor, and delivery (e.g., fetal heart or vital sign monitoring, vaginal examinations). When questioned as to why, they indicated that they never really thought about these things, and although these tasks were not unimportant in the overall scheme of things, they were not aspects of care that the women remembered. To them, the midwife "being there" was as essential as her "doing for." It was the special way that the midwife was with the woman that was recalled and described and emphasized by participants:

And she was always there physically, close and touching, which was important. And reassuring. I think not so much--it's just her voice and knowing she was there and I could see her even when I closed my eyes, I knew she was there. I knew. I sensed her presence.

My first child was born four years ago but I can see the face of the midwife in the bathroom, (pause) breathing with me, and different times--very clearly. Probably always will, I think.

Presence, derived from the Latin "praesentia", refers to a person's appearance or bearing, a person's force of personality (Allen, 1990). The phrase "to presence oneself" comes from Heidegger's Being and Time (Benner & Wrubel, 1989, p. 13). The German words "Anwesenheit" and "Zugewesenheit", meaning "to enjoin" or "to be accessible", were translated to the closest English equivalent. "To presence oneself with another means that you are available to understand and be with someone. [It] contrasts with standing aloof and outside the situation, or being preoccupied with other thoughts while being physically present" (Benner & Wrubel, 1989, p. 13). The health care provider who has this ability can truly be with the patient in a unique and special way.

In relating their stories, the participants quite frequently referred to the sense of presence exuded by their midwife, particularly when attempting to describe what it was about her care that enabled them to cope more effectively with the labor and delivery. This special aura was not dependent on caregiving that was obtrusive or overt. Instead, participants recalled that the greatest feelings of security and comfort were derived from simple things, from just the midwife's way of being. They spoke of her physical closeness and her touch, her breathing along with them through painful contractions, being able to look into her eyes to find reassurance. In particular, participants referred to her voice, and

in many instances, it seemed to be not so much what she was saying, but the rhythm and the tone and the hope that the voice conveyed. It seemed as if these special aspects of the midwife's presence had an almost hypnotic quality, and provided an atmosphere of calm and tranquillity:

I remember him [partner] breathing with me but I remember her voice. I remember her voice talking to me. And that was about all I could hear.

I just found looking into her eyes, focusing on her while I was breathing, while I was going through the pain and I just got tremendous reassurance from that.

... and she took me by the face and she said "Breathe with me" and after that, I just never lost a beat.

In addition to the power to comfort and console, the midwife's presence at the time of childbirth helped alleviate the woman's fear and feelings of vulnerability, and reminded her of her own strengths and abilities. So the sense that the midwife was there, truly with them, made these women feel it was possible for them to continue on, to believe that they could do this:

I'll always remember when [midwife] came into the room the day of the birth ... and laid her coat down and the big smile and those eyes--you know (laughs) and just the warmth and everything. ... Oh, I just felt so confident! And I was really looking forward to it rather than dreading it.

I was just looking for someone to hold my hand and get me through this. ... And make me believe that it was possible to do this 'cause if you've never had a baby, it's hard to believe (laughs) you can do that, you know? And that's what she did. ... It's nothing that she said or did. I mean, it's just her, her presence, her confidence. ... She just has a very soothing, calming way about her. ... The chaos and fear just isn't there.

Another aspect of the midwife's presence described by participants was the impression that she gave that she was there only for them and that they were important. The midwife had no other distractions, no other patients to see, and to these women, it seemed there was nothing more critical to her at the time than being with the laboring woman throughout the birth experience. Several participants voiced the opinion that, in general, the other health care providers were "just watching for the baby." They were more interested in the safety of the baby or the physical act of delivery, while the midwife was "looking out for [the woman]." Thus the midwife had the ability to make each woman feel cherished, esteemed, special. Although the midwife obviously had attended numerous births in the past, participants voiced the feeling that, at the time, it seemed theirs was the only one. There was a distinct sense that, for the midwife, caring for the laboring woman was more than a routine, more than a job. It was something she wanted to do because she derived satisfaction from sharing in the process and helping to make the experience of bringing forth a new life, a richer and more fulfilling one for each woman in her care:

I mean, she was there for so long. It was as if nothing else was important. I was the only thing that was important to her at the time. . . . Everything stopped while she was with me.

And you need somebody who can concentrate only on you. . . . And, you know, [she] may have seen hundreds of births, but makes you feel that you're the only one?

I knew she was doing this because she was interested in doing it. That she was interested in me. And that made a big difference.

Participants emphasized that the midwife's presence was a crucial part of her ability to provide care during childbirth. This quality was such that the



midwife became a main focal point for the woman at this time. It seemed as if everyone and everything else, that was outside of the comforting cocoon of midwifery care, just ceased to be important:

So you have all these different people, and you're nothing to them and they're nothing to you, you know. . . . But still, knowing she was there, I was able to think about her and nothing else.

Several participants stated that knowing the midwife would be with them for labor and delivery was more important than having their own family doctor or obstetrician. For instance, 2 participants surmised that if their doctor had not been willing to work with a midwife, they would have changed doctors antenatally instead of giving up the midwife:

I think [midwife] did enough for me, that if I didn't have a doctor, it wouldn't have mattered. She could address everything.

In addition, all of the women indicated that the midwife's presence during childbirth was more valued than even that of their partner, no matter how involved or supportive he might have been. They attributed this to various reasons, offering explanations such as "they only know so much about what you're going through," he "didn't have the touch," and "he didn't know what to say." The women believed their husbands alone, without the midwife, just would not "have had the same effect."

[Midwife] was there to do those things that needed to be done. My husband didn't have a clue! (laughs) So, it just made that triangle work. It would have been a two-legged stool without [midwife]--it wouldn't have worked. 'Cause I love him dearly, but he doesn't know anything about birthing babies or hospitals or how this works, you know?

Although in most instances it was evident that the women wanted and valued the continual presence of the midwife throughout labor and delivery, 2 participants made remarks which reflected on another aspect of this theme. It seemed that not only was the midwife a sustaining presence, someone the woman relied on to remain with her when the going got tough, but she was also able to offer a selective presence, if this was something the woman desired. The midwife seemed to know when her constant presence was not required and was able to adjust her role to provide reassurance without actually being physically present at all times:

She'd walk with us up and down the halls a few times but really realized at points that, you know, we needed to be alone and we'd walk the halls alone. And we'd sort of touch base with her every so often. . . . She was just very sensitive to us and what we wanted and needed at that moment.

And she was with us I think at least half an hour. . . . Then after that she left me with [husband] and [baby] and just getting to know each other and make our phone calls. But she popped in and out the whole time to see how it was going.

Overall it appeared that the midwife's presence had a great impact upon how the women viewed the childbirth event. In many instances, the midwife's presence was able to make the difference between a routine birth and the birth that the woman really wanted—one which truly surpassed the limits of ordinary experience. In her interview, Ella\* contrasted her first birth (which was not attended by a midwife) with the second, clearly illustrating the impact that the midwife's presence had made to her experience:

And with the first, I just felt like I fell prey to the system and it robbed me of an event that I wanted to be mine and my

family's, not another hospital procedure. . . . Anyways, with the second birth, it was like having a little tea party (laughs) through labor and the delivery. . . . It was a perfect labor and a perfect delivery and I felt good about it afterwards.

**Intuitive knowing.** Intuitive knowing was a fifth theme which emerged from the data: participants' belief that their midwife was able to sense and in some instances, anticipate their needs during labor and delivery. She was described as being sensitive to the kind of care and support each woman required at any particular point in time, sometimes when even the woman herself was not aware of existing needs. To sense, from the Latin "sensus", refers to "the ability to perceive or feel or to be conscious of the presence or properties of things." A sensitive individual has a "quick or accurate appreciation, understanding, or instinct regarding a specified matter" and is "very open to external stimuli or mental impressions" (Allen, 1990, p.1102-1103). The participants viewed their midwife as such an individual, a person who recognized and responded to their needs, thus enabling them, in turn, to respond to each new challenge inherent in the birth experience:

She knew what I wanted before I wanted it . . . you know, so then, before anything got to the point of hard to live with, she sort of solved the problem.

Like, she could anticipate things. Like when the breathing had to change. . . . So she sensed a lot of things quicker than I could. . . . She just knew. It was a connection. Yeah. It was unspoken.

For the woman in labor, who is being swept along by a sea of pain, new sensations, and the incredible power of the birthing process, it is often essential that support be there without the asking. Participants recalled being so caught up in their own experience, so inwardly focused and deeply involved within their

body, that often it was impossible for them to identify or express their own needs. Their body seemed to be taken over by sensations and emotions that were bewildering, exhausting, and, at times, exhilarating. Chesler (1979) wrote "I was somewhere on the ceiling, out of reach, out of hearing. My thoughts were in one place, my body in another" (p. 255). The women spoke of the way in which the midwife "just seemed to know" what care they required, was aware of various techniques for alleviating the pain and discomfort, and intuitively knew when use of these techniques would be most beneficial. Marie likened it to "going through labor with this wonderful cushion around you," which made the whole experience much more tolerable. It was as if the midwife could read the woman's mind, a kind of inner listening to the other person, a responsive awareness of the woman's needs. Janet commented

She'd suggest things to me--different positions, like on your side, that I didn't know. When you're wrapped up in that you can't imagine, you know. . . . She was following right along, doing things in a logical, sensible way.

How is it that the midwife was able to respond to the distinct needs of each laboring woman, when every birth experience was so unique, each woman's journey so unmistakably her own? The participants believed that this ability, in part, stemmed from the midwife having factual knowledge of the childbirth process, from clinical expertise in having assisted many women through this process before, and perhaps from her own personal experiences with childbirth. For as much as each labor is unique, there are also commonalities, such as signs indicating passage from one stage of labor to another, or particular comfort measures which have been shown to be effective for certain types of labor discomforts. Thus the midwife was able to use a degree

of intuition, as well as learned observational and assessment skills, in order to plan for effective interventions to meet many of the woman's needs. Donna illustrated this point with the following:

I guess I just felt it was experience and not necessarily as much medical experience as (pause) maybe a reading of body language or something like that. It probably is fairly routine that you go through certain phases, and you know, if you have back labor, then that happens at a certain point --it gets worse and that type of thing. And I think I thought it was just experience with the process of childbirth itself.

However, it seemed that the midwife's in-depth understanding of each individual woman's needs extended beyond the mere possession of textbook knowledge or reliance on past experience. Participants expressed the opinion that it also required the establishment of a special relationship antenatally, one in which the midwife invested sufficient time, interest, attention, and effort to become familiar with significant experiences in the woman's past, her current concerns and fears, and her expectations and goals for the childbirth event. Thus, at the time of labor, the midwife had prior knowledge of each individual woman and was aware of her unique needs. Ella\* explained

When you have a relationship with someone and not a doctor-patient relationship, you are in tune with people's feelings. Because there's more of a depth of knowledge there between a midwife and a client than there is between a doctor and a patient in my experience, in general. I think there's a (pause) deeper understanding of the person.

Participants also linked this ability to sense needs to the fact that the midwife remained with the woman for the duration of her labor. Unlike the nurse, who might have been in and out of the room, attending to other responsibilities,

the midwife was a constant companion to the woman. Therefore she was able to follow the woman's progress (or lack thereof), assess her response and her ability to cope, and then determine which comfort measures or other interventions would be appropriate and when they would likely be most effective. "The complexities of childbirth, for each unique individual mother and child, can be comprehended by an intuitive, experienced birth attendant who is attuned and present throughout the birth--not just in and out every few hours to 'do an exam,' but really there" (Stewart, 1977, p. 295). Janice stated

She *never left*. She was *always* there. I mean, nurses come and nurses go. I mean, like I said, if you're *there*, you can see the progression of things. You can see that it's slowing down or it's going fast or this isn't normal or this girl is not handling it as well as she was an hour ago, you know what I mean? She knows, not necessarily by what I said, but just by being with me and seeing the changes in me and the changes in the progression of the labor. . . . I think, like I said, knowing as much as she knew, it was like she could anticipate something before it happened?

Finally, participants believed that, in order to truly sense needs, the midwife must also possess the ability to empathize. "Empathy is the equivalent of German *Einfühlung*, which literally means 'feeling into' " (Hardin & Halaris, 1983, p. 14). It refers to "the power of identifying oneself mentally with, and so fully comprehending, a person" (Allen, 1990, p.383). The empathetic individual has the capability to "enter into the life" of the other person and accurately perceive his/her current feelings and their meaning. However, the empathetic health care provider does not "get lost" in the client's world, start feeling sorry for the client, or lose his/her competence in providing objective and effective care:

And I mean, sometimes it was even as if she was going

through the pain with you, you know?

She was like, well, in a way, she was going through labor too. There's an empathy there.

As participants described their midwife's character, it was evident that she did indeed possess unique relational capacities. It seemed that during labor, she was able to become one with the woman, step into her shoes, so to speak, and feel what she was feeling. Participants spoke of the midwife as being "in tune" with them or having "a connection" with them. In their discussions, several participants went so far as to refer to the midwife as sort of an "auxiliary ego" (Cogan & Spinnato, 1988, p. 210) or "a proxy," suggesting total identification of the midwife with the needs of the woman. Denise commented "[she] knew me better than myself." Although she was acutely tuned in to the woman's experience, the midwife did not, however, get caught up in the powerful tide of emotions that the woman was encountering, as a loved one, such as a partner, might. Nor did she allow the sights and sounds of the woman in pain to detract her from effectively fulfilling her role. Rather she was able to step back from the woman's experience, interpret the woman's feelings, and identify needs. Donna discussed this idea with the researcher:

... you almost had to have somebody ... to be able to understand what you were going through. ... You know, somebody who was objective enough because they weren't related to you. It wasn't your mother and it wasn't your sister and it wasn't your husband. They weren't emotionally involved in the sense of you having pain or whatever. But yet, they knew the process well enough to be able to understand, OK, how you were reacting and how that translated into what was going on.

In summary, it was because of the close relationship established with the woman, the midwife's constant presence throughout labor, her professional experience with childbirth, and her ability to empathize, that the midwife was able to sense needs and decide what support was required, sometimes before the woman even asked for it. It also allowed her to determine when a particular technique or intervention would be useful and when it was no longer effective. Participants suggested that this intuitive knowing could not come from reliance on objective measurements such as vital signs or cardio-tocograph monitoring. Instead, the midwife had learned how to tune in and listen to the woman and read her body signals. This offered her a deeper and fuller appreciation of the woman's experience and allowed her to be better prepared to meet the mother's needs:

There was a sense that she knew when to do things, you know, when the back rubbing was going to be good and when it was too much, when to stop.

She had that skill, and she was connected with my body and my mind, I guess. . . . So that's the empathy. She was tuned in to me. . . . If you're just meeting someone for the first time, you wouldn't have that relationship. So the relationship was there and she knew me. She knew my personality, and what I was going through.

There had to be some kind of a connection like that, that I, probably because it was so physically difficult for me, wasn't even aware of at the time. You know, things just seemed to happen. . . . Yeah. To spend time watching you and understanding what's going on. And I mean, it's more than reading the tape on the monitor, you know.

**Seeking safe passage through the expertise of the midwife.** Another important theme was the idea of the midwife as expert, someone who would



ensure the woman safe passage through childbirth. In most developed countries, with the shift towards increased medicalization of childbirth, there has also been a shift in society's attitude away from a view of pregnancy and labor as a natural physiologic function, to one of childbirth as a harrowing and painful event. Rubin (1983) wrote that pregnant women often have "an unrealistic and frightening image" of childbirth, imagining it as "a searing, splitting, and destructive experience" (p. 247). "Labor and delivery are seen as a double jeopardy to self and child: there is a danger of not surviving or surviving impaired by loss of function, of body parts, or of body intactness" (Rubin, 1984, p. 55).

The women in this study referred to the unknown and unpredictable quality of labor, even repeat birth experiences could be quite different from the first. They indicated that they had been uncertain as to what to expect and unsure of what means they should use to cope throughout this process, when familiar bodily responses would be replaced by unfamiliar ones and trusted coping mechanisms might be of little use. Participants recalled feeling "nervous," "anxious," "vulnerable," or "afraid." For half the participants, these feelings persisted, to some extent, throughout the pregnancy, birth, and postpartum, while for others, these feelings surfaced mostly early on in the pregnancy, prior to contact with the midwife. Even though their partners would be with them for the birth, the women recognized the need for someone else--someone who would not only be a supportive presence, but who would also bring the knowledge and expertise necessary to ensure a safe and successful passage. The midwife was seen as this individual, someone who was an expert in pregnancy, childbirth, and the postpartum, someone who would educate and

prepare the woman. but who would also remain with her as a guide throughout the process:

And safety was a big thing. The first thing I thought about was I had to have somebody there I could feel safe with.

It's a complete unknown and it was really important for me to have somebody who I saw as an expert in childbirth--and midwives are who I see as experts in childbirth--attend the first birth.

It was just a feeling that I had that if you had somebody who was experienced with childbirth and could maybe help you through some of the more difficult periods, that, you know, the chances of it not becoming a crisis, or that type of thing, might be better.

An expert, from the Latin "experiri", refers to a person having special knowledge or skill or one who has tried out or experienced something thoroughly (Allen, 1990; Family Word Finder, 1975). It was evident in the way that participants spoke, that they had placed a lot of confidence and trust in the midwife's expertise. Participants believed that part of the midwife's expertise was derived from her educational background: the factual knowledge and learned skills she possessed because of her specialized training. They surmised that this expertise could also be derived from personal experience--the midwife having had children herself. However, participants seemed to feel that, for them, the most important aspect of the midwife's capability stemmed from her clinical experience or having previously assisted many other women through the childbirth process. This offered the woman a tremendous amount of reassurance and convinced them that the midwife was the professional they needed to educate and prepare them and guide them safely through labor:

And you look at all the experiences she brings to my labor--all the labors she went through before, her own personal experiences and everything else. She just has such a broad spectrum of knowledge.

Certainly her experience as a mother. . . . I guess her wealth of experience in knowing what a woman goes through in labor. . . . She just exuded competence and professionalism. . . . I just felt she had a very practiced hand. . . . She was knowledgeable and obviously had assisted in many, many births.

But I guess in a sense I felt --and maybe particularly with her --that "Well, gee. She's been through this" and more the fact that she'd been through it with other people in a sense, and had a lot of experience. . . . It's not necessarily personal experience but experience with a number of people. I think I'd feel less comfortable with a novice who'd maybe only done 2 or 3 and didn't have the range of experience that you hope somebody had.

However, it was evident from the women's stories that their willingness to put total trust in the midwife as an expert, and their ability to learn from her wisdom, involved more than simply the possession of knowledge on the midwife's part. She also had to be able to establish a relationship with each woman antenatally, and create a climate conducive to learning, one in which the woman felt comfortable and encouraged to learn. Teaching plans were individualized based upon assessment of each woman's needs. Information was presented in the light of the woman's own goals and agendas, and not those of the midwife. Participants recalled being respected as individuals, being listened to, and being treated as equal partners--as Denise recalled "she never discredited anything" that the woman suggested. Each woman was informed, rather than lectured to or given empty reassurance, and encouraged to make her own decisions. Kitinger (1979) stated "it is much more valuable to give people

information and *self confidence* so that they can make their own informed choices in terms of the reality they face" (p. 15). This view of the midwife often sharply contrasted with participants' descriptions of other professionals within the health care system. For example, Ella\* referred to the doctors as "more dictating to you versus you contributing." In addition, a number of participants commented negatively regarding the group prenatal class they had attended during pregnancy, one woman even going as far as to say that she "hated" them. They talked about the absence of individual attention, the lack of personal interaction with the instructor, the medical (i.e., pregnancy as illness) focus of the discussions, and the instructor's lack of specialized knowledge:

In the practice [independent midwifery practice in the United States], the midwife had actually asked for a birth plan: "What do you want?" You know. "What do you see happening?" . . . Things like that. So we were going through a choice--that I had a lot of say in it?

I think in order to feel respect, in any way, you need to have input and have someone respect your decisions. . . . Certainly, you just feel midwives respect the whole birth process.

She wasn't the boss and I wasn't (pause) it wasn't, you know, a subservient kind of interaction there. . . . I mean, I didn't feel like a child and she the parent or teacher, and you know, there was none of that sort of tension.

Participants described the midwife as someone who always seemed to be available to them during the antenatal period. She never gave the impression of being rushed, or having something of greater importance to attend to when she met with the client for prenatal appointments. Even Lee\*, who had been cared for by a midwife with a busy practice, recalled that "she never gave us the

impression that . . . she was hurried. . . . Even though she had a room full of patients!" Participants spoke of being surprised by the amount of time the midwife devoted to prenatal care, and how she made herself accessible by offering home and work phone numbers and encouraging the woman to call her at any time.

Closely related to this notion of midwife as accessible, was the view of the midwife as approachable. Participants believed she was someone who they could turn to with any questions or concerns, no matter how small or trivial, and not be made to feel silly or stupid. They indicated that they did not feel comfortable taking these concerns to their doctors because the doctors "didn't have time," were "abrupt and anxious to get on with things," often "talked down" to them, treated them like "an ignorant person," and generally gave the impression that they did not "respect [the woman's] concerns." With the midwife, concerns and worries were validated, and as Lee\* explained, this made the woman even more likely to ask the midwife "embarrassing things," "pour out stuff," and "open up more" to her. Obviously, this offered the midwife increased opportunities to educate and inform. The participants' view of the midwife as approachable and available also extended into the postpartum period, when the woman turned to her midwife for guidance with parenting and breastfeeding:

So you don't ever feel that, you know, anything is too much trouble. No question is stupid. You know. It's just that she's there, she's completely open.

I wanted somebody who I could ask what I sometimes felt I couldn't ask in a medical doctor's office, because it seemed so small and trivial. I was almost embarrassed to ask some of the questions that I felt far more comfortable bringing up with my midwife before labor and delivery. And after labor and delivery, it was someone who I felt I could call on and

ask her, again, things that seemed very small and trivial if I were to bring them up to a doctor, but it was what was weighing on my mind at that point.

Rubin (1984) suggested that, for the mother-to-be, "ensurance of safe passage is done primarily by a loading of knowledge of what to expect, the probable and the possible, and of how to cope with the manifest phenomena" (p. 55). As participants recounted their birth stories, it was evident that the midwife had been an incredibly important source of information for the woman and her family throughout pregnancy, labor, delivery, and postpartum. Participants related how, antenatally, the midwife taught them about the breathing and relaxation techniques and different types of massage, familiarized them with the hospital routines that they may encounter, and told them what to expect during labor and delivery. In the intrapartum period, she educated them regarding any interventions that became necessary, and kept them informed of their progress through the stages of labor. In particular, several participants spoke of times during their labor when they were really "starting to fade" and feeling like "I can't do this." It was at these difficult times that they turned to their midwife to find out "what was going on," and the progress markers she provided then, gave them the "strength and courage" to keep going. Finally, postpartum, the midwife provided instructions on breastfeeding, self care, and early child care. Her knowledge and expertise was sought, utilized, and highly valued by all participants through the entire childbirth process:

And she'd come to the house every week or two weeks and go through the breathing and exercises and things with us and we obviously discussed what would happen if I did have to have a cesarean because of the [medical condition].

I certainly wasn't there in the middle of labor reading a book, trying to find out what this meant and what that meant, you

know--she was there.

She also helped me with breastfeeding. Even though it was my second baby and I breastfed my first, I found it was a different experience. . . . I remember [midwife] coming in and sitting down with me and talking to me while I was breastfeeding and giving me a hand with the latching and all that kind of stuff.

There was one other important aspect of the midwife's role as an expert which was revealed in the interview data. The women indicated that, during pregnancy, they found it very beneficial for the midwife to teach them various techniques which would help them cope more effectively with the labor process. However, participants emphasized that, to only have someone impart information, by itself was not enough. For example, with Ella's\* first birth, the midwife had cared for her antenatally but had been away at the time of her premature delivery. Ella\* described how she had learned the breathing techniques both at prenatal classes and from her midwife. However, at the time of labor, although she had tried to use the breathing and her husband had encouraged her to use it, "it all became so scary and so out of control" and she "couldn't do it on [her] own." It seemed that, for these participants, the greatest sense of comfort and security was derived from the fact that, at the time of labor, the midwife would be with them, an expert professional who could encourage and assist them in the use of the knowledge and skills they had acquired antenatally. Fear was decreased not by education alone, "but by not being abandoned, by being attended and helped through the valley of the shadow that all women walk to have a child" (Rubin, 1975, p. 1683). As they reflected on their birth experiences, participants believed this was what got them through it, this was what really helped them attain safe passage:

It's all very well but you don't know how you're going to react at the time. . . . And I think you know when [midwife] comes to your house and you're learning the breathing, the whole reassurance behind that is that she's going to be there at the time with you. It takes the fear out of it. You know that you're learning this but she's going to be there with you at the time. That's what you need to know most.

You know, if someone teaches you how to swim and then, all of a sudden, you know, you're left on your own. To know something in your head is one thing, but to be able to go through it and practice it, is another. So I don't know how good I would have done without her. . . . You know I think her being there was as important as the information she gave.

And having taught you those things doesn't make a *damn* bit of difference unless you have that person beside you entering into those experiences, having that support by your side. The knowledge is important but you need someone to help guide you as to when to use the knowledge that you have.

**Seeing the whole: The woman as part of a family.** A seventh theme arising from the interview data was that the midwife was able to see the woman within the context of the family, as opposed to her just being a "pregnant person" cared for in isolation from significant others. Although the initial question to participants asked that they focus on the care the midwife had offered them during pregnancy, labor, and delivery, at some point in their discussions, all participants also mentioned the role their partner had played during the birth, the ability of the midwife to involve the partner antenatally and/or during labor, or the sensitivity of the midwife to broader family needs. Several participants frequently discussed the midwife's care in terms of what she had done for "us" instead of "me". It appeared that the women viewed their midwife's care as encompassing more than just attention to the needs of the pregnant client:



But that relationship and that sensitivity to the experience and to you as a family unit--seeing you as one--is crucial.

Participants were encouraged to expand on their ideas of how they felt the midwife was involved within the broader context of the family. They indicated that although the midwife's main focus was on the woman as an individual and the care she would require in order to effectively prepare for labor, the midwife was also sensitive to the fact that the woman was part of a family. The midwife extended her care to be responsive to family needs and involved significant others, particularly the partner, in the childbirth experience. However, she always took her cues from the woman with regards to the extent of family involvement that was desired. As Denise explained

She could include him in if I wanted it, but she respected my feelings. And that was important. So there was no judgment call there. 'Cause [partner] wasn't involved with any of the sessions when we got together [antenatally]. So he was involved, you know, when I was delivering. And we talked about that.

Participants expressed appreciation of the fact that the midwife was able to see them in the context of their family. Two of the 5 participants who had been cared for by a midwife during a second pregnancy, specifically remarked on the midwife's interest in or ability to involve their other child. Lee\* recalled that, during her second pregnancy, having the midwife "care about the other child in the family" was very important to her, and something she had often thought of since the birth:

The next time she came [first child] was involved in it and that was important too. She saw us breathing and practicing and

(pause). She got a big kick out of seeing [midwife] drop my arm [for relaxation exercises]. For months after that, she'd practice with me! (laughs) So I guess the midwife coming to the home really involved the whole family.

And even, you know, when she came to the house after I had [second baby] or when I was pregnant and we were doing the breathing, she was so interested in [first baby], and she remembered when he was a baby, when he was born, and all that. You know, it really meant a lot? (Janice)

Most frequently, participants discussed the midwife's interaction with their partners, as opposed to any other family member. All of the partners planned to be involved to varying degrees in the antenatal preparation (e.g., prenatal appointments and classes), the labor and birth events, or both. Most of the partners intended to take an active part in the process of labor and delivery, and planned to assume the role of labor coach and support person. For example, Marie remarked

. . . and my husband took quite seriously the breathing exercises that we were assigned to do. . . . You know, he took his role as assistant labor coach very seriously.

Although these men were interested and willing to help, it was much like entering uncharted territory without a map. With increased participation comes increased expectations, and the women speculated that their partners were ill-equipped to fulfill their new role. Their knowledge and understanding of pregnancy and birth was limited. Their personal experience with childbirth might have been non-existent or restricted to a previous birth event. However, participants indicated that the midwife recognized and addressed the partners' needs. For those men who wished to take part, the midwife adapted the care she provided antenatally in order to include them, sharing her knowledge and

expertise, and assisting each expectant father to become more involved in the pregnancy and to prepare for his role during childbirth. For example, participants spoke of the partner "hearing the baby's heartbeat for the first time," learning the breathing exercises, and being motivated to "read more." Several participants commented on the flexibility of the antenatal appointments with the midwife. The partner was much more likely to be present for appointments planned in the evening hours or conducted in the couple's own home, than he would for doctor's office visits scheduled during day time hours when many of the men were at work. Other participants remarked that their partners were "not comfortable" going to the doctor's office or asking questions of these busy professionals:

He became much more involved in the breathing and actually contributing to the decision making. . . . [Husband] just felt more encouraged to take part--or able to take part as well. I'd say not only encouraged, doors were open to him.

She really answered all of his questions and even when she came 'round in the evenings, she'd chat to him about how he was feeling and was there anything that he needed to know in exactly the same way that she did with me.

[Husband] was involved in [midwife's] visits and . . . she explained to him as well as to me about the relaxation and the breathing and what to expect. . . . He felt really involved --and was involved.

Participants voiced a belief that, at the time of labor, not only did the midwife care for them, but she cared for and supported their partners as well. They described how the midwife encouraged their partners to participate and guided them as to how they could be most helpful to the laboring woman. The men became involved in providing comfort measures such as giving back rubs,

offering ice chips, walking with the woman, and coaching the woman in the use of breathing techniques. Participants suggested that the midwife's view of labor and delivery as normal events helped to reassure and calm the expectant fathers, as did their belief and trust in her knowledge and expertise. Her acceptance of pain as a natural part of the childbirth process helped the men to cope better with seeing their partners in discomfort, and have faith that all was progressing as it should:

If [midwife] could see that he could do something--I remember she did get him to get ice chips a lot and that's important that he could do that. . . . So if he could do some of the stepping and fetching, it made him feel useful, I suppose.

So I think that having somebody to talk to or whatever, having somebody to say "Well, go get a cup of coffee now" or "Go get some lunch" or whatever. (pause) But in a more specific sense, to say, you know, "Things seem to be all right" or "Maybe you could try this" or that type of thing.

Another aspect of this theme was highlighted by participants as they discussed the idea that the presence of the midwife during labor was able to relieve some of the "pressure" experienced by the expectant father. They spoke of him being able to "share the burden" and not feel "responsible for the whole thing." He did not have the responsibility of being the sole coach for the laboring woman and knew someone else was there if his partner needed more support, guidance, or reassurance than he was able to provide. Nor was he expected to be the labor authority or the protector, someone who would somehow "save" his partner from the discomforts of labor or from unwanted interventions by the staff. Participants believed that this helped prevent tension from building within the relationship, which could have occurred if the couple had been alone and afraid:

She was a huge support to him. The whole weight of the thing didn't fall on him to keep me calm, and look after me and trying to help me through the pain.

... he was just as happy, in the sense that, you know, he didn't have to do everything for me? He could share the burden. ... And if I was, you know, demanding [husband] like "What does this mean?", "Go get someone!", "Do this for me!"--it would have just added, you know, a bit of tension to the room and he would have probably felt really stressed if he couldn't do what I wanted and he couldn't be there for me, you know?

I think it allowed him to be more a calm spectator. He didn't have to be an actor. ... It would take a lot of pressure off him and our relationship would be a lot more relaxed because [midwife] was there to do those things that needed to be done.

Participants speculated that the security offered by the midwife's presence also allowed the expectant father to focus on becoming more involved, to truly be with his partner, and to enjoy the miracle of birth. As Denise recalled

... he said it was a wonderful experience to experience because (pause), not just the birth, but the whole experience of delivery and how natural it was.

Although the midwife was mainly referred to as filling a supportive role for the couple during labor and delivery, 2 participants noted incidents when she was sensitive to the couple's need for privacy. At certain times throughout the birth process, the midwife recognized that the couple would like to share time alone, and adjusted her care to provide for this:

I found a midwife incredibly sensitive to the family. ... She sensed when we would want her to walk with us or when we would prefer to be on our own and was very comfortable with that.

The woman's relationship with her midwife was the focus of much of each interview. Yet several participants did spontaneously suggest that the midwife had also established a close and personal relationship with their partner. They spoke about how the new fathers felt "very close" to the midwife, "grateful" for her care, and aware that "the benefits" she offered had extended to them and not just to the pregnant woman. In these cases, it appeared that by recognizing and responding to family needs, the midwife was able to form a strong bond with the expectant father, as well as with the woman who was the main recipient of care. Ella\* declared

He feels incredibly close to [midwife]. I won't say closer than me but it's incredible the bond he feels to [midwife]. And my husband is very shy, very, very private, and he becomes incredibly animated with [midwife]. (laughs) Really, much like he is with his sisters and it's wonderful to see. I think her care touched him deeply.

**Maintaining control while letting go.** Another predominant theme which emerged from the data concerned the issue of power and control surrounding the childbirth experience. Although it was undoubtedly an important issue for all participants, each woman discussed the issue in a slightly different way. The amount of control desired, expected, and actually experienced varied from one woman to another. Their individual stories wove a complex web, in which was entangled a desire to maintain control and independence, a willingness to give up personal power to the midwife but not to other health care providers, and a need to surrender to the physical power of labor in order to allow optimum progress to delivery:

Birth is such an incredible experience and with the midwife, it really is a very empowering experience. It was incredibly

powerful.

And we do have power in our bodies and giving birth and being pregnant and having a child is empowering.

Control, from Medieval Latin "contrarotulus", refers to the power of directing or commanding. It is to have charge of oneself, others, and/or events in the environment (Allen, 1990; Family Word Finder, 1975). Control or domination of others is an issue which may surface when individuals involved in a situation are unequal: in terms of factors such as social status, experience, knowledge, or credentials. Such might be the case when the pregnant woman is being cared for by professional health care providers. The woman who receives care in a large, modern hospital or from highly educated professionals is at risk of "no longer feeling herself actively the creator, the 'I' who in her unique way makes her unique baby" (Kitzinger, 1978, p. 96). These professionals, whether intentionally or unintentionally, often take control of the childbirth event. However, maintaining control of oneself and/or the environment becomes an issue of critical importance for many women during a life event as extraordinary as giving birth:

I just thought this is probably the most powerful experience I will have for the rest of my life: a birth (pause). Maybe death will be similar (laughs). Walking in or walking out of something.

It is evident that there is the potential for a power differential between the midwife and the woman she cares for during childbirth. By virtue of her clinical expertise, her knowledge of the childbirth process, her past experiences with birth, even her licensure and title--the midwife is in a position of authority relative to the woman. Although participants readily acknowledged the midwife's expertise, not one of them viewed the midwife as someone who wielded control

or who dominated the situation. The woman and her midwife formed a partnership rather than a relationship based on dominance or authority. The midwife was seen more as a facilitator: an individual who assisted each client to develop and use her own personal power as a woman and as a mother. Three participants specifically used the word "advocate" when referring to their midwife. Advocacy means helping the woman help herself, rather than taking over, controlling or making decisions on her behalf (Perez & Snedeker, 1990):

Like she had the power because of her expertise. . . . So she had the power there and the skills and the knowledge. My power was that she treated me as a human being and empowered my feelings and was tuned in to them.

Oh, they [the two midwives who had provided care in the United States] gave me control right up front. . . . And I think that there was never an issue that the midwife was in control. It was never that sort of feeling?

It's like they [midwives] don't take away your power, they empower you. So that you feel that "Hey. We're in this together."

For all participants, there was a common need to exert some degree of control over the childbirth process. However, the extent of this desire to be in control at different stages throughout the process varied from one woman to another. All women wished to participate in decision-making antenatally (such as in the development of a birth plan), to have questions answered honestly, and to be as informed as possible so as to be able to make appropriate choices for themselves and their babies. Several participants expressed their interest in learning various breathing and relaxation techniques antenatally in order to better prepare themselves for labor. They would then have some means of



coping with the pain, and thus be able to stay in control of their behavior. Janice stated

I didn't want to be one of those women who started swearing and being a different person and attacking my husband while I was in labor!

Participants saw the midwife as the individual who fostered this control during the antenatal period. When providing care to the pregnant woman, the midwife did not project her own ideas and opinions on the woman. Rather she provided the woman with clear, honest information and ensured that she was aware of all options and the consequences of each. In addition, she assisted the woman to ask the right questions of other health care providers. The midwife also taught the breathing and relaxation exercises and discussed with the woman the purpose of these exercises during labor. Her aim was to educate, and enhance the woman's self-confidence, thus encouraging and supporting the woman's efforts towards independence. The midwife was described by participants as someone who works with pregnant women: "advising," "supporting," "educating," and "nurturing," so that each woman grows throughout the experience, her knowledge base is widened, and she feels competent and prepared:

I really felt comfortable asking [midwife] questions. I felt like I was making better choices after I had seen [midwife].

Like she didn't give me any opinion on whether or not I should have an episiotomy. She gave me some information to read and she said "You make up your own mind about it."

Although all participants expressed the desire to be in control antenatally, there was a realization that, at the time of labor, their ability to be in control

would be compromised: because of the pain they would be experiencing, the need to maintain safety for themselves and the fetus, and the total unpredictability of the labor process itself. There was a recognition of the fact that the woman in labor cannot intellectually control or direct the process. She cannot, for example, make the contractions shorter or less painful, or control the time of delivery. Chesler (1979) wrote " . . . 'I' wasn't needed during labor, when a force deeper, more ancient than my own will took over" (p. 183). Several participants expressed the belief that there is a need for the woman to "let go" during childbirth, to relinquish control to nature, and yield to the energy and power that is traveling through her body. Thus, the woman in labor often experiences a confused feeling of "power and powerlessness, of being taken over on the one hand" (Rich, 1976, p. 17), and the possibility of uncovering hidden strengths on the other:

You're powerless really. You can have all the knowledge on how it should go but in the end, basically, there's a part that you have to let go. And [midwife] talked to me about that. She said that "Denise, when you're in labor, often the women that have the easiest labors are the ones that can go with the flow." It's not that you give up the power but you respect your body.

I figured I was going to have all the control. . . . But that's not the way it was. That's our need to be in control. And it doesn't exist. So I know now that if I had another child, I would be even more willing to let go.

Labor was a time when the women realized that they needed to rely on the advice and judgment of a trusted and knowledgeable individual in order to help them make decisions or influence the actions of other health professionals involved in their care. They also depended on this individual to guide them in the use of techniques to enable them to maintain self-control and to cooperate with

the physical forces of labor. For example, Janet discussed use of the breathing techniques during labor:

The breathing was important, just pacing. Because if you're in a lot of pain, it's easy to lose it and if you lose it and the pain can kind of over-power you? . . . But you know, with her there helping you with the breathing, I mean, you just kinda [sic] keep a lid on things.

Once again, the midwife was seen as the individual to fill this role during labor. Several of the women indicated that they were content to relinquish much of their control to the midwife at this time, to allow her to make decisions for them, or to intervene on their behalf. Others saw her as more of a safety net--someone to fall back on if they were unable to exert control themselves, someone who would filter in necessary information to help them make appropriate decisions, and who would uphold their decisions in the presence of other hospital staff:

I had complete faith in [midwife] and what she supported I would have accepted. I hate to not know what's going on and so, of course, whatever was happening, I'd want to know, but yes, I was very happy actually for her to look after things for us.

She's kind of a funnel for everything that would get back to me? . . . [Midwife] somehow would filter it all through so that I think I actually made some decisions, but it was much easier for me to think about everything 'cause she sorted it out.

I wanted to know everything that was going to happen and what could happen, and if this happened, what did that mean. . . . I was glad that she was there because I could ask her anything.

This decision to trust in the midwife's judgment and allow her a measure of control was not something which was extended to other health care providers, such as the nurses assigned to the woman at the time of admission to hospital,

or even, in some cases, to the woman's own family doctor or obstetrician. Participants spoke of "not depending on" these professionals, "not trusting" them, and being unwilling to take their advice. Several participants reported feeling "uncomfortable" or "disappointed" if these individuals did take control of birth events at any time (e.g., perform an instrumental delivery):

I wouldn't take any advice from the specialist--even if they are a specialist. I would take complete advice from [midwife].

In giving up control you have to be comfortable that you're giving it to the right person . . . and to some extent--it may not be fair to obstetricians--but I feel they're the guys who show up at the last minute and just do things.

How is it that the women in this study felt comfortable in allowing the midwife, but not other health care providers, to fill this important role during their labors? Participants explained that with the development of the relationship between the midwife and client antenatally, the midwife came to know, understand, and share in the client's philosophy of birth. Each woman placed faith in the midwife: that the midwife was there for her and would support what she wanted. Her questions, decisions, and choices would not evoke a negative reaction from the midwife, nor would she be punished for choosing an option that might be contrary to the midwife's beliefs. Ella\* stated

My image of a midwife is somebody who educates and then supports and then empowers the woman. "That's fine. That woman has made those choices. This is what she wants. This is going to be her family. This isn't a medical procedure within my hospital. This is this woman's experience and her birth and I'm going to help her get what she can from it."

There was a very strong feeling among participants that the midwife was not part of what they referred to as "the system": the traditional medical model of care. As much as she was a trained professional and a member of a team of health care providers, she was seen as distinct from the doctors and nurses who operated based upon hospital routines or policies, and not upon the individual needs of the woman. Participants believed that the midwife was not a component in this system, nor would she be coerced by it. She was not employed by an institution but rather commissioned by the woman. Thus, she was not in a position of having to serve two masters. Her sole focus could be on the woman and what it was she wanted in her birth experience:

Well, I saw the system as really male-oriented and basically, it was a way of doing things. It was a structure. . . . I don't see midwifery as connected with the medical system at all. . . . To them, it's routine. They don't gear it on one-on-one. They don't look at the individual needs of the person at all . . . everyone's labor is treated the same.

I guess I feel with an obstetrician or other people working within the hospital setting, my interests, what I wanted from the birth is not uppermost in their mind. They would make decisions based on efficiency and "Let's get this over with before the shift is done." . . . Whereas I think the midwife . . . would do everything in her power for me to get what I want from that birth.

If initial plans did have to be altered during labor or delivery, the woman believed the midwife was someone they could turn to who would outline and discuss the implications of various alternatives, and offer advice consistent with the woman's philosophy of birth. Ultimately, the final decision would be the woman's to make. There was a sense of the woman maintaining a sort of "guided control." Ella\* illustrated this point:

With the midwife telling me that, I feel that I could actually converse with her and say "Well look. I didn't really want this." And "No. But this is what's happening." And I think ultimately I could still pull back and do what I wanted to do, although I would always take the advice of somebody who I had trusted.

However, in the end, the midwife was viewed as the expert in childbirth. Therefore, if at any time, the woman was unable to rationally participate in decision-making or control the events around her (e.g., the actions of other health care providers), she felt comfortable to rely on the midwife's judgment, or allow the midwife to make some decisions or intervene on her behalf. As Donna explained

The decision to give up control is not easy, but if you know the person you're doing it with and you know that they've had experience with the medical people, and have the knowledge, and it's not such a hard thing to say "O.K. Look. I trust you to be able to intervene when it's necessary, because you know more than I do."

In most instances, however, the participants did not see this "turning over the reins" as actually relinquishing control because they believed that the midwife's decision would be in their own best interests. Several participants actually expressed the idea that the midwife was almost like an extension of themselves, a "proxy", and as such, would make compatible choices. Even the decision to give control to the midwife was, in itself, the woman's own decision, and not something forced upon her. Participants saw it as "giving away" as opposed to someone "taking over". They indicated that, with the midwife, there was never a sense of losing control, of feeling like "I don't have a part in this."

Instead, their stories portrayed a "covenantal relationship" (Cooper, 1988, p. 49), characterized by mutuality, reciprocity, and responsiveness:

But I gave over to her. You know. "Well if [midwife's] there, that's what I want to do." It's not that she asked for it. It's not that she actually took it. I gave it to her.

. . . you just want to trust that whoever is guiding this is going to be working in your best interests and will understand what you need. . . . So it's everything that you need but you can't do it. You can't speak for yourself. . . . So she's kind of like your spokesperson. You give it all over to her. But it's because you trust her. And she's just kind of you in proxy? . . . When you trust the person who's leading you by the hand, it doesn't feel like you're out of control. It's not chaos. There's a plan here. And it's your plan. She's just taking it, you know, she's going to speak for you.

Overall, participants reported that they came through the birth experience with a sense of power, satisfaction, accomplishment, or strength, even when some aspect of their labors or deliveries turned out to be not quite what they had planned. They did not express a sense of failure or loss of control if medication, operative delivery, or other interventions had become necessary, as long as they had been part of the decision: if they were consulted and informed and treated with respect. Several participants expressed a belief that, as a result of their midwife's care, they had been able to maintain control throughout: of themselves, of decisions that were made, and/or of circumstances surrounding the birth:

I felt completely in control and I felt very confident about who was beside me.

The birthing was long and hard but I felt like a champion. You know. "I did it!"

**Midwife as trusted and trusting.** A final theme which elucidated the women's experience with midwifery support was that of trust. Trust, from Old Norse "traust", refers to a firm belief in the reliability, truth or strength of a person or thing (Allen, 1990). As participants related their stories, it was evident that there were two different sides to this theme. All of the participants saw their midwife as a trusted caregiver, one in whom they placed great confidence and faith. For example, she was someone who could be trusted to intervene on their behalf with other health professionals or make decisions for them when they could not. This implicit trust, which was bestowed upon the midwife, was not given to any other health care provider. Apart from this belief that the midwife was someone who could be trusted, participants also described a perception of the midwife herself as trusting. They described how she trusted in the birth process, in nature's own way, and in each woman's ability to give birth. The midwife believed in the woman and thus encouraged the woman to believe in herself.

As the women relayed their experiences, they gave the unmistakable impression that their trust in the midwife was absolute and unshakable. This trust formed the basis of the relationship, it was the foundation upon which all succeeding interactions were built. The notion of trust was also very clearly interrelated with many of the other themes identified in the data. Even prior to the initial meeting with the midwife, participants had placed trust in her as a safe and expert practitioner. This instinctive trust was reinforced throughout the antenatal period as the midwife answered their questions, provided individualized teaching, and responded to even the most trivial of their concerns. Participants indicated that they believed the midwife would never do anything



that was not in the best interests of the mother and child, or that would place a baby or the mother at risk. This offered participants a sense of security and peace of mind, allowing them to face the unfamiliar and unknown challenges of pregnancy and childbirth with a minimum of fear:

She had our total trust and that's probably the biggest thing isn't it?

I felt I could trust her. And that was really important. I wanted someone I could feel safe with and trust.

It's a trusting relationship. 'Cause you're so vulnerable and you want somebody that you know can be there for you.

This relationship of trust, which matured and flourished during the pregnancy, became a critical ingredient in the actual birth experience. The women trusted in the midwife to be there throughout, to never leave them alone. They trusted in her to intercede on their behalf with other health care providers to ensure their wishes were respected. It was because of this unquestioning trust invested in the midwife that participants felt comfortable in following her advice, accepting her judgment, or even surrendering control to her, when it became necessary to make important decisions during labor or delivery. There was also a sense that participants trusted in the midwife to "worry about the other things", leaving the woman free to focus on the physiological demands inherent in the childbirth process:

And I felt a great sense of security with [midwife] at the bedside.

And in this kind of situation, you really want to be able to trust somebody. I mean, almost literally with your life, in a sense of it being a very traumatic and very stressful, and a physically stressful time.

I believe that . . . she would only suggest [something] when she knew it was really in my best interests. . . . The bottom line--I would say that because I trusted her. . . . I would go with what she suggested.

You really have to trust who you have and I feel incredibly sorry for people who don't have someone who they can trust at their birth.

Several participants pointed out that, not only did they place trust in the midwife, but it was evident from certain incidents that had occurred during their birth experiences, that her decisions and abilities were also trusted by other health care providers. For example, Janet recounted an incident where the obstetrician, who was called in because of her prolonged second stage of labor, "was quite happy to stand back and just let things go" because he trusted in the midwife's judgment. As Denise stated

They respected her and they entrusted the care of me with her. . . . They trusted her too.

Although a tremendous amount of trust existed between the woman and the midwife, this was not extended to other health care professionals, despite the fact that several participants spoke positively of the obstetrician, family doctor, or staff nurse who was present at their births. The women attributed this difference in trust partly to the existence or non-existence of a relationship between themselves and the particular health care provider in question. Participants indicated that it was very difficult, if not impossible, to trust someone who they had never met before the birth, such as the nurse assigned to them during labor or the obstetrician who happened to be on call. In contrast, the trust between each woman and her midwife developed within the special relationship that began antenatally. However, simply knowing or having a professional

relationship with a health care provider prior to labor was not sufficient to engender the sense of absolute trust such as that invested in the midwife. Several of the participants did have a family physician or obstetrician who provided antenatal care and thus were known individuals at the time of labor and delivery. Although a certain amount of trust was placed in these professionals, they were still seen as part of the system and more likely to act based upon hospital rules or policies, rather than in the best interests of the woman and child. Participants therefore found it difficult to award them that unquestioning trust that was given to the midwife:

The trust thing I think is what it is . . . a trust has been established? That you can't have with total strangers when you go into labor in a hospital. You know, you're laboring in a hospital with strangers so there's obviously no time to establish trust. I don't think any of us have a blind faith any more in the medical establishment. . . . I didn't trust them implicitly. . . . When different procedures were recommended, I would sort of turn to [midwife] "What do you think?"

I think I would trust her judgment far more than I would trust somebody in the hospital setting. I just don't think they'd be working for me. They'd just be working to get this done--get this procedure done and over with.

I gave that to [midwife] right off the bat. I said to her "This is what I want in my birth plan--none of this stuff--unless you deem that that's the way to go." I wouldn't say that as quickly to a doctor because I think he would take that route faster. But the midwife would try alternatives, give it more time. . . . Yeah. It is trust.

The other important part of this theme was the participants' view of the midwife as trusting. Participants believed that the midwife was someone who trusted in the birth process, and in each woman's strengths and possibilities.

She saw birth as a normal physiological event, one that a woman was capable of conquering, and one that should bring the woman a sense of accomplishment and satisfaction. This did not mean however, that she believed all women should birth without interventions or medication. For those women who had already drawn from their own resources and then found it necessary to take advantage of medical technology to complete the process, the midwife reassured them that they had still faced and overcome one of life's more difficult challenges. For example, Marie, who had required a vacuum-assisted delivery, still described her birth experience as "beautiful," and recalled how the midwife had reassured her afterwards: "You pushed, you know. . . . You did it. It wasn't the machine that did it. You did it." Participants described their midwife as having a "positive connection" with labor and birth, and being able to "see so much more to the process" than just safe delivery of a normal infant:

They [midwives] truly believe that women can . . . birth as naturally as possible and should have a very rich experience.

[Midwife] really saw it as something that could be quite beautiful. . . . I remember when I went into labor, I was trying to think that! (laughs) . . . And I think, well, that's a real switch. I mean, nobody has ever said that to me-- that it can be beautiful.

The midwife's firm belief in the power and ability of each woman's body to give birth, encouraged participants to believe in themselves. She planted the seeds of competence, capability, and fortitude in the woman's mind antenatally, prompting her to develop confidence in her own judgment and abilities, to take charge of planning for the birth. The midwife encouraged the woman to trust in her own body and follow its rhythms. "Faith in the process of birth frees a woman

to guide, steer, or ride the waves of her labor. Faith is a pre-requisite for an experience of control in birth, or anything else" (Peterson & Mehl, 1985, p. 388). Then, during the advanced stages of labor, when pain or fatigue threatened to undermine the woman's determination, the midwife assisted each woman to discover and draw on inner strengths. Participants revealed how they became more confident about their ability to endure, overcome, or perhaps even triumph over the challenges inherent in the birth event:

She didn't say it but she showed me over the course of time that . . . if you don't try and work with what's happening to your body, you're not going to help yourself.

I think she helped me reaffirm my belief that I could get through it?

I remember once she said to me "You can get through this," you know, "You're doing fine." So she gave me that encouragement. . . . I trusted her in that. The encouragement kept me going.

She said . . . "You can handle it" and "We'll do it together." So I knew as long as she believed I could do it--wonderful. . . . that was OK. We could get through it.

### **The Relationship Among Themes**

Phenomenological themes may be conceptualized as the experiential structures which make up an experience. As such, they are only parts which fit together to form a whole, threads around which the phenomenological description is woven (van Manen, 1990). Each theme cannot be considered as an isolated entity. As van Manen (1990) stated "one theme always implicates the meaning dimension of other themes" (p. 168). In other words, the themes which

have been described, explicating women's experiences with midwifery support, are all interconnected and dependent upon each other. The remainder of this section will outline the relationship among those themes, thus offering a phenomenological description of the experience of receiving midwifery support throughout pregnancy, birth, and the postpartum, from the woman's perspective.

It was evident from participants' stories that trust was a predominant theme throughout their experience, and this notion of trust was strongly interrelated with many of the other themes that emerged from the data. Prior to even the initial meeting with the midwife, participants placed a certain amount of trust in her abilities simply because she was seen as an expert in childbirth, someone who would be able to provide them with necessary education and information, and someone who would be quite capable of guiding them safely through the process. This sense of trust was reinforced with the development of a special relationship between the midwife and client antenatally. How could they not trust an individual who to them, represented the ideal mother?

The midwife's constant presence throughout the antepartum, intrapartum, and postpartum periods again reinforced the sense of trust. Reciprocally, the women came to rely on the midwife to always be there. Like the ideal mother, she was trusted to never leave them alone during childbirth. This continuity of care, provided within a special relationship, allowed the midwife and the woman to get to know each other in a personal and intimate way. The midwife's in-depth knowledge of the woman and her constant presence throughout the childbirth event contributed to her ability to sense, or even anticipate, the woman's needs during labor. For participants, to have their needs met without asking, only

served to enhance their belief in the midwife's expertise and in her ability to safely guide them through the childbirth experience.

Although the constant care provided by the midwife was, in itself, very important to participants, it became evident through their stories, that continuity was not an isolated theme. Family doctors sometimes provided continuity of care throughout the antepartum period and during late first, second, and third stages of labor. Nurses might also have been present throughout most of the labor and delivery. For the midwife, it was not just the fact that she was constantly present, but it was also the nature of that constancy. In addition to being physically present, the midwife exuded a special presence, which perhaps could also be referred to as a special mothering: an ability to make each woman feel cherished and cared for, to feel that the midwife was there, totally focused on and committed to them and their experience. The women's partners also benefited from the midwife's presence and her expertise, as they were relieved of the burden of being the sole authority and protector for their mates, and were guided as how to contribute to the woman's care in a helpful and meaningful way.

As a child looks to the mother for guidance and protection when faced with difficult life events, participants relied on the midwife to fill a buffering role during labor and delivery. The women sought her expertise and knowledge antenatally in order to prepare for the childbirth event. This buffered, to some degree, the extent of the unknown. It also allowed the women to more intelligently participate in decision-making surrounding the birth process, thus preventing powerful others from imposing decisions without the woman being an active contributor. The fact that other health care providers also trusted and respected the midwife as a knowledgeable and safe practitioner, protected the

woman from unwanted advice and suggestions or unnecessary interference by these professionals. Finally, the midwife's constant presence acted as a kind of physical buffer, as the number of other staff required to be present was kept to a minimum.

The ultimate test of trust is perhaps when an individual can "give over" to another person, rely completely on that person's judgment, and allow that person to make decisions on their behalf. Study participants indicated that they felt this way about their midwife. They felt confident to relinquish control to her at certain times throughout the labor, and trusted in her to make choices which would be in the best interest of mother and child. Their decision to give up control to the midwife was, in turn, related to their faith in her expertise and the fact that she had been a known constant throughout their pregnancy and childbirth experience. Participants felt it was safe to surrender control to someone with whom they had formed such a close and personal relationship. Like an ideal mother, the midwife was relied on to take care of them when they could not take care of themselves. Ultimately, it was the trust placed in the midwife which also freed the women to let go and work with the labor process. If this expert practitioner believed in their ability to overcome this challenge, why then, shouldn't they believe in themselves?

Without the midwife, participants envisioned a birth experience without a buffer, a situation where they would lose control and likely be alone through much of the journey. They stressed that her constant presence had been invaluable and that childbirth just "wouldn't have been the same" without her. More than just a luxury or a frill, the midwife and the quality of care she had provided were seen as essential and irreplaceable aspects of the entire



experience. This notion was the whole which subsumed all other parts (i.e., themes) and formed the very nature of the experience: the essence.

### **The Essence**

Through formal, unstructured interviews, participants were encouraged to reflect upon and describe their lived experiences with midwifery support. The researcher then spent considerable time exploring and pondering the interview data in an attempt to uncover the "internal meaning units" (i.e., themes) that made up the experience (van Manen, 1990, p. 10). It was only through the study of the particulars that the researcher was able to move closer to grasping the true essence of the phenomena under investigation: What was it that gave this particular experience its special significance? What made this experience what it was, rather than it being something else (van Manen, 1990)? In the end, the researcher identified the essence as follows: For the women in this study, the midwife was seen as an essential and irreplaceable dimension of the birth experience. She was never viewed as a complement to the hospital staff, an "additional feature" who made the birth more pleasant. Instead, it was evident that, for these women, the midwife had made the birth experience what it was--without her, childbirth would have been a completely different event.

The word "essential" comes from the late Latin "essentialis", and refers to that which is absolutely necessary or indispensable (Allen, 1990). This aptly portrays the way in which participants viewed the midwifery support they had received, particularly during labor and delivery. The quality and continuity of

care provided by the midwife was considered to be invaluable, a vital ingredient in the birth event and its overall outcome:

I mean, I couldn't have done without it [midwifery support] . . .

For me, she [midwife] was "the thing."

I mean, my doctor only came . . . at the end. So she [the doctor] was significant per se, but [midwife] got me through it all.

The women in this study did not see midwifery care as an "extra" or a fringe benefit, something that was good to have but not necessarily crucial for a positive experience. Several of the participants actually made statements such as "without [midwife] it wouldn't have worked," "I don't know how well I would have done on my own," and "I don't know how I could have done it without her." For a few of the women, their midwife was scheduled to go out of town soon after their due dates and possibly might not be available at the time of labor onset. Participants recalled the apprehension induced by this possibility, and emphasized how critically important it was for them to deliver before the midwife left. Janice recalled

See, she was going away the end of May, and I used to say "I gotta [sic] have this baby before you leave." I said "I'll go on a bumpy road!" (laughs) I said "I'll get cream put on my cervix before you leave. I gotta [sic] have this baby while you're here."

During their second interview, participants were asked to imagine what their labors and deliveries would have been like without the midwife in attendance. In all instances, the women were rather pessimistic in their replies. They described their images of a birth without a midwife as being a "completely impersonal" event where the woman would be "without emotional support" and

would likely "lose control" of the situation. They imagined negative emotional states, suggesting that they would have been "frightened," "panicked," "insecure," "stressed," or a "nervous wreck." They questioned "how good" or "how involved" the staff would have been, and if they would have kept the woman adequately informed. As Donna commented "I mean, yes, you're going to have the baby--but it won't be the same." It was obvious the participants believed that, without the midwife, the experience would not have been what it was. Instead they would have experienced a totally different labor and birth:

Without [midwife]? I can't even imagine. (pause) I don't think I would have been able to cope.

I really couldn't imagine going through it without a midwife. It would have been a real nightmare I think.

I can't imagine not having her there. It would have been really awful.

Two of the participants, who had delivered their first child without the help of a midwife, did recount negative experiences where they felt they had lost control of the process and had unpleasant encounters with staff. For example, Ella\*, who had spontaneous rupture of membranes at 37 weeks, described her first birth experience as follows:

I went into hospital and of course, didn't go into labor--I think partly because of the fear . . . and just too much on the go in the mind to actually let labor come on. The next day, they did recommend an induction. . . . I felt completely *out* of control with the labor and delivery, and I think I had a hard time with postpartum because of that (pause). It took me a long time to work through the actual birth experience itself.

The contrast between these participants' two birth experiences was strikingly apparent as they recalled the events surrounding their labors and deliveries. The negative incidents encountered during the first birth factored strongly into their decision to involve a midwife in the second pregnancy.

All the participants who were considering having more children (and even several who weren't) indicated that they would want to have a midwife care for them if they did become pregnant again in the future. Once they had experienced childbirth with a midwife involved, they just could not envision going through labor and delivery without her:

I'd have the same thing again, I mean, I'd definitely like to have another midwife for the next baby. . . . There's nothing to beat it.

I don't know what it would have been like to have never had her--but now that I've had her, I don't think I would go through it without her.

The 3 participants who received midwifery support during both of their pregnancies and births stressed that the midwife's care had been just as important, if not even more important, the second time around. Janice explained

And I think too . . . you sort of know what they can do for you more the second time 'round. . . . I knew what I could expect from her. I really had a better grasp of her role after the first time, so I felt I [would] benefit from her to the maximum that I could.

Several women pointed out that midwifery care was not just for women anticipating normal or natural childbirth experiences. They suggested it was perhaps even more critical for those women with high risk pregnancies who harbored many fears and anxieties, and who were at high risk of losing control of

the process as much as they were at risk of potential negative outcomes.

Sarah\*, the participant who needed a cesarean delivery, indicated that it was "even more . . . necessary to have her there because it was so frightening having to have surgery."

As participants discussed the care and support given by the midwife, particularly during labor and delivery, they expressed the opinion that it had been more than they had ever "hoped for" or "expected". They remarked on how the midwife had been such an "incredibly important" part of the whole event, and referred to her as being "the key," "the lifeline," someone who made the experience "a lot better," "a lot easier," or something "really special." It was evident from their stories that, for these women, the midwife's care was cherished, valued, and viewed as irreplaceable:

It was one of the smartest things I ever did . . . that made a big difference to the birth itself.

I think it's a really valuable thing to have done, and I'd recommend it to anybody. . . . Of anybody in that room, the most valuable person . . . to me, was the midwife.

All it [the experience of having a midwife] does is deeply ingrain in me the fact that it is essential to have somebody like that with me. . . . You never know what's going to happen.

The midwife held the crucial role of director of the drama. The women believed that it was only with her support that they were able to play out their script for that ideal birth. Ella\* captured this notion when she stated:

I had a very natural, wonderful labor and delivery. . . . If I could have written the birth, I would have written this birth. It was exactly what I wanted. I felt completely in control and I felt very confident about who was beside me.

## **CHAPTER 5**

### **DISCUSSION**

Being a recipient of midwifery support was described as a deeply personal and emotional experience by the women in this study. They spoke of intimate relationships that extended beyond the boundary of the normal professional-patient relationship, and a depth of trust that is normally extended to only the closest of family and friends. This chapter is a discussion of these women's experiences with midwifery support. The first section discusses some of the themes which have been identified, in relation to the literature. The second section of the chapter offers new insights into the experience of receiving midwifery support during pregnancy and childbirth.

#### **Discussion of Themes in Relation to the Literature**

Several themes warrant discussion because they add to or confirm what has been explicated in previously identified areas of research. One such theme is presencing: participants' belief that the midwife offered a special presence throughout the childbirth experience. Prior research, which focused upon the care provided by labor and delivery nurses, revealed that subjects rated the provision of supportive care (emotional support, affect or affirmation support) more highly than physical care (tangible or aid support; Bryanton et al., 1994; Kintz, 1987; Mackey & Stepans, 1994; Shields, 1978). These results were supported in the present study in that participants rarely mentioned the technical

aspects of physical care provided by their nurse-midwife, choosing instead to focus on the emotional and psychological support which was an inherent part of the midwife's presence.

Mackey and Lock (1989), Mackey and Stepan (1994), and Shields (1978) all specifically discussed the concept of presence as it related to labor and delivery nurses. A main aspect of this concept for participants in these studies was the nurse's ability to be a selective presence. Participants varied quite significantly in how much they desired the nurse's presence throughout labor and delivery, and spoke highly of those nurses who were able to discern the need / non-need for their presence at any given time. In the present study, although 2 participants did refer to the idea of the midwife as a selective presence (and in one instance, this applied to the immediate postpartum period and not during labor), this was not a main aspect of the theme. Overall, the women in this study preferred that the midwife maintain a constant presence throughout the childbirth experience. As a matter of fact, participants indicated that her presence was more highly valued than that of their husband or their doctor.

This difference in findings may be due to the fact that the midwife was a known individual, someone with whom the woman had developed a close and intimate relationship during the antenatal period. The midwife was seen as being "part of the family." This contrasts with the labor and delivery nurse, who is a stranger assigned to the woman at the time of admission to hospital. The woman had placed trust in the midwife as someone who would ensure safe passage and an optimum birth experience. As such, the woman valued the midwife's

sustaining presence as an insurance that she would be more likely to attain her goals.

The presencing theme as identified in this study has also been noted by other researchers whose investigations have involved caregivers in work settings other than labor and delivery. For example, the work of Benner (1984), and Benner and Wrubel (1989) addressed the concept of presencing. This ability "to be with a patient in a way that acknowledges . . . shared humanity" was one of the competencies in the helping role, an important domain of nursing practice (Benner & Wrubel, 1989, p. 13). Benner (1984) discovered that some nurses were aware of the essential importance of just "being with" a patient, instead of always feeling it was necessary to be "doing for" (p. 57). Kermode (1995), who used a phenomenological approach to study the experiences of 8 men recently diagnosed with an AIDS-defining illness, with their nurse caregivers, also noted a presencing theme. These men recalled nurses who had a genuine connection to and concern for the patients, and who gave patients a sense that they really cared. The presencing theme described in the present study also closely resembles Drew's (1986, p. 40) "experiences of confirmation", as described by participants who recalled positive interactions with caregivers. Drew (1986) conducted a phenomenologic exploration of 35 patients' experiences with caregivers on a surgical and an obstetrical / gynecological unit. Experiences of confirmation referred to situations in which the caregiver acted as a "human presence" (p. 40 ) for the patient: acknowledging the patient's feelings and giving the impression that they wanted to be there and cared about what happened to the patient. The present research indicates that presencing by



caregivers is not limited to situations involving illness, but is also of great importance at the time of a major life event, such as giving birth.

Another important theme, which is mentioned in the satisfaction with childbirth literature, is that of control. Results of both quantitative and qualitative studies have pointed to self-control, participation in decision-making, and control of events in the environment as crucial factors contributing to women's satisfaction with the childbirth experience (Brown & Lumley, 1994; Bulani & Hodnett, 1980; Davenport-Slack & Boylan, 1974; DiMatteo et al., 1993; Green et al., 1990; Sequin et al., 1989; Simkin, 1991). The findings from this research indicate that control during childbirth is a more complicated issue than has previously been considered. All participants wished to make informed choices and participate in decision-making antenatally. They also wanted to learn techniques which would enable them to maintain self-control and cope with contractions. However, at the time of labor, when pain, anxiety, or fear might negatively affect a woman's ability to make rational decisions, and the woman's body seemed to be completely taken over by an involuntary process, the notion of maintaining control became more complex.

Several participants discussed the labor process and the importance of letting go: relinquishing the need to control bodily functions and sensations and instead, tuning in to one's body and allowing oneself to be carried along by the energy and power within. Participants also described a need for the constant presence of a trusted, known individual who could keep them informed, help them make decisions, and if necessary, assume a measure of control on their behalf. This is similar to some of the findings in the grounded theory research by Bluff and Holloway (1994; e.g., the women saw their midwives as experts who

could make decisions concerning their care). However, in contrast to the participants in their investigation, who indicated they sometimes were unsure as to why decisions were made, the participants in the present study indicated that they were always kept fully informed. There was never a sense that they were unquestioningly accepting decisions made by the midwife without understanding why those decisions were necessary.

Participants felt comfortable to give up a certain amount of their control to the midwife because it was believed that she was somehow an extension of themselves, someone who would act in their best interests. Women indicated that even the decision to give up some control was their own, and not something forced upon them by the system. Even though they had taken the midwife's advice on various matters or depended on her to make some decisions for them, several participants voiced the opinion that they had felt "completely in control" or "empowered," and had experienced a sense of satisfaction and accomplishment following the birth.

From these findings, it seemed that the women were aware of potential disadvantages in maintaining rigid control of their behavior and bodily processes during labor. Thus "self-control" may also include an element of being able to "let go." In addition, in situations where the woman is cared for by a known and trusted caregiver, the need to be in control of the situation and of decisions made, may also encompass the decision to hand over some control to this individual and allow the caregiver to make decisions on one's behalf. However, when assuming this responsibility, the caregiver is still expected to keep the woman informed of what is going on and to always act in the best interests of mother and child.

A third theme which has been addressed in the literature is the concept of buffering. Much of this literature has focused on the stress-buffering effects of social support. For example, S. Cohen and Syme (1985) introduced a buffering hypothesis, proposing that social support exhibits its influence primarily in the presence of stress by acting to shield or buffer individuals from the negative consequences of stress. S. Cohen and Wills (1985) outlined some of the conditions necessary for social support to be an effective buffer to stressful life events. Walker (1992) summarized 13 studies (of pregnant women, expectant couples, new fathers, or new mothers), 11 of which found some evidence of a relationship between social support, either as a direct or a buffering effect, and various health outcomes. Rubin (1983) approached the concept of buffering in a somewhat different manner, and applied it specifically to childbearing. She described the dissipation of body boundaries occurring during pregnancy, labor, birth, and the postpartum, that disrupts a woman's normal protective response against external assaults or forceful intrusions into her body. She suggested that the pregnant woman then acts to protect herself in two ways: by distancing herself from the intrusive forces (e.g., by avoidance), and by setting up a buffer zone through the sustained presence of another individual.

The findings of this study confirm and add to what has already been written regarding buffering. It was evident that participants viewed midwifery support as a shield against stress, whether this stress be in the form of anxieties regarding the unknown, or the unwanted presence of other health care providers. It appeared that the women in this study did indeed set up a protective buffer zone, with the midwife functioning in a buffering capacity between them and the system. However, her role as a buffer extended beyond

simply protecting the woman from physical "assaults" or intrusions into her body. It also meant keeping the number of staff present down to a minimum and deterring them from intervening with unwanted advice and suggestions. It involved educating and informing the woman so as to lessen fear of the unknown and to allow the woman to intelligently participate in decision-making, thus lessening the chance of decisions being imposed upon her. It meant speaking up and representing the woman's interests to other health care providers when the woman was unable to do so herself. Participants believed that, by functioning in this buffering role, the midwife was able to influence the outcome of their labors. Although their dream for the perfect birth may not have been realized, participants felt that the midwife had helped them attain an optimum birth experience, the best deal they could obtain under the circumstances.

Previous research into the role of labor and delivery nurses has failed to specifically identify intuitive knowing, or some version of this theme, as a supportive behavior valued by participants, although several studies mentioned the importance of attention to individual patient needs, receiving personalized care, or making the woman feel cared about as an individual (Bryanton et al., 1994; Field, 1987; Kintz, 1987; Mackey & Stepan, 1994; Shields, 1978). Benner (1984) did address the anticipation of patient problems and patient care needs as characteristics of expert nurses, but her research was not specific to obstetric nurses, and focused more on illness experiences. Many other authors have written on the topic of intuitive knowing (e.g., Agan, 1987; Miller, 1995; Rew, 1988, 1989) but again, their work was not specific to labor and delivery nurses or to nurse-midwives. It is worth noting here, however, that Rew (1989) discussed a sense of a spiritual connection that existed between intuitive nurses and their

patients. This was one aspect of the intuitive knowing theme which emerged from the data in the present study.

For the women in this study, the midwife's ability to sense, and in some instances, anticipate their needs, was an invaluable aspect of her care, which helped ease their progress through the turbulent and challenging experience of labor and delivery. It seemed from the participants' stories, that this ability to truly sense needs required, among other things, the existence of a relationship prior to labor, and the constant presence of the care provider throughout the labor. The existing structure of modern obstetrical care often does not allow the nurse to remain with a woman for the duration of her labor, particularly if it is a lengthy one, and labor and delivery nurses seldom know the woman prior to admission, and thus are usually unaware of her hopes and desires for the birth. Therefore it is more difficult for them to sense each individual woman's needs, and they must rely instead on generalities or textbook knowledge. However, as Benner (1984) stated "anticipation is very contextual" and must be "based on what is occurring with a specific patient, rather than what might happen to patients in general" (p. 102).

### **New Insights into the Experience of Receiving Midwifery Support**

The present investigation has uncovered new insights into women's experiences with midwifery support during pregnancy and childbirth that have not been discussed in previous research. One such finding was the depth of the relationship established between the midwife and her client, such that the woman came to view the midwife as an ideal mother. Secondly, new insight into

the meaning of continuity for care-recipients is possible by examining the way in which participants defined continuity of care and by acknowledging the significance they attached to the constant presence of a known individual who was truly with them during childbirth.

**Looking beyond the professional-patient relationship.** One theme highlighted by this research, which was not evident in the literature reviewed, was the midwife as a maternal representative. The notion that the midwife and client could develop such a special relationship that the midwife would come to be viewed as the ideal mother (in several cases, more supportive or important than the participant's own mother), expands previously held beliefs concerning the possibilities inherent in the care provider-care recipient relationship. The participants spoke of the immediate bond that appeared between themselves and their midwife, the close and intimate relationship that was shared, and the difficulty they had with finding closure once the professional relationship had ended. It was evident that the connection between the midwife and client extended far beyond the professional-patient relationship, such that, in the woman's eyes, the midwife assumed the role of a most important family member, the mother. This special relationship was built on factors such as the provision of continuous care throughout pregnancy, labor, delivery, and the postpartum, the communication of respect for the woman as a full and equal partner, someone capable of making her own decisions and choices, the sense of a shared philosophy of birth, and the image of the midwife as an expert but nurturing health care provider who was available, approachable, and willing to listen.

Unfortunately the structure of our present day health care system does not encourage the development of such a special relationship between care provider and client. With so many general practitioners in Newfoundland withdrawing from the provision of maternity services, many women with normal pregnancies are being referred to an obstetrician at some point during the antenatal period. This individual is often a stranger, with a busy practice, whose main focus is the abnormal or high risk pregnancy. The individual woman's wishes and needs are often not a priority. In addition, there is no guarantee that the same obstetrician will be on call if labor extends after hours or occurs on the weekend. Even if the general practitioner continues to provide maternity care, women may find the antenatal visits structured, rushed, and not conducive to the intimate sharing and relationship building, as was noted with the midwife in this study. The family doctor's presence through labor is sporadic in most cases, and they usually arrive near the end of the first stage, in time for delivery, and leave again soon after. Labor and delivery nurses are likely to be individuals the woman has not previously met, and as participants in this study indicated, it is very difficult to form a close and trusting relationship with a stranger. In addition, the nurses are influenced by a shift system and a myriad of other responsibilities, which often leaves little opportunity for the provision of continuous care throughout a woman's childbirth experience.

For many of these professionals working within the technologically-driven health care system, the constant development of new equipment and new machinery has convinced them that birth is a dangerous process, and that women's bodies are unreliable and incapable of functioning well on their own and so, must be controlled and dominated by technical procedures and

practices. This attitude is not conducive to allowing the woman herself to be the dominant voice in how the labor is managed, and she is unlikely to feel respected or listened to throughout the process.

None of these present day realities in obstetric health care create a climate favorable to the development of a relationship such as that described by the participants in this research. There is a need to change the view of pregnancy and birth as disease conditions, and to see the woman as more than a minor player in the game. There is a need for a system of obstetric care which provides more continuity than is presently being realized. There is a need for a shift away from the provision of technical and physical aspects of care to a more nurturing approach, with emphasis on the woman's emotional, informational, and spiritual needs. It is only by changing our present approach to the care of the pregnant woman that health care providers can hope to be rewarded by a relationship that is deep and rich, one which transcends the boundaries of the usual professional-patient relationship.

**Expanding the definition of continuity of care.** Professionals who work within or who write about the health care system frequently talk of continuity of care. For some, this may mean assigning a nurse to the same unit for two or three consecutive shifts, so that the patients on that unit are cared for by a familiar individual. Continuity becomes the degree to which the patients are cared for by the same nurse during their hospitalization (Bostrom, Tisnado, Zimmerman, & Lazar, 1994; Seaborne, 1993; Shukla, 1985). For others, it may mean passing on a detailed report to the oncoming shift or carefully documenting patient needs, requests, and preferences (Pobojewski, Neper,



Guzzo, & Beadle, 1992). This ensures that important patient information is accurately communicated, and allows care to continue with as little disruption as possible. Continuity may also mean implementing a system of primary nursing whereby one nurse plans care for a number of patients over all shifts, as opposed to a system based on task assignment that fragments the patient's care needs into various tasks performed by different staff members (Shukla, 1985). Finally, continuity of care, to many health professionals, may mean planning for discharge in a timely fashion and hospital staff liaising with community health nurses to enable the patient to make a smooth transition from hospital to home (Sullivan, 1995). All of these actions are important steps towards maintaining some degree of continuity of care for the patient. However, the vision of continuity espoused by participants in this study goes far beyond these types of actions.

For the women in this study, the need to fight against the fragmentation encountered within the health care system was an important factor in their initial decision to seek midwifery support. Continuity of care meant having a caring relationship with the same midwife from pregnancy through to the first few weeks after childbirth. It meant believing that this individual was available and accessible to them, not only through scheduled visits, but also by telephone. It meant feeling comfortable enough to approach the midwife with any questions or concerns, no matter how trivial. The women wanted an individual who would be committed to the process, someone who would be known to them at the time of labor onset, and who would remain with them throughout the entire labor and delivery, no matter how long that might be.

For these women, it was crucial that they be able to establish an open and trusting relationship with their midwife prior to labor. Mutual self disclosure and sharing of personal information were important components in this process. The participants explained that, not only was it important for the midwife to come to understand and share in the client's philosophy of birth, but it was also important for the woman to know and understand the midwife's views, beliefs, and usual manner of providing care and support. The woman could then enter labor confident that there would be "no surprises." In turn, the midwife would know the woman's idiosyncrasies, dislikes, and preferences. The laboring woman could relax and place total confidence in the midwife's abilities, and feel secure in the knowledge that her midwife knew what she wanted and what was best for her. The woman could even rely upon the midwife to make some decisions for her if at any time she was unable to make decisions for herself. When the drama of delivery was over, the midwife remained with the woman, providing physical care, assistance with breastfeeding, and praise and commendations for a job well done. For the 8 participants in this research, all of these factors were seen as vital aspects of what we refer to as "continuity of care."

This vision of continuity cannot be realized within the present structure of obstetric health care in Newfoundland. Although some improvements have been made over the years, obstetric care remains fragmented and in many cases, impersonal, and is perhaps becoming more so with the large numbers of general practitioners withdrawing from providing maternity services. The family doctor might well have been the only individual the woman knew who provided care throughout her pregnancy, birth, and puerperium. The nurses working in the

labor and delivery area are rarely known to the pregnant woman prior to admission. Even after the nurse has formulated some sort of relationship with the woman following admission, continuous care may be difficult to provide, as that nurse may be assigned to several clients simultaneously, may be scheduled for inservices, or may be reassigned to other clients or in-charge duties. The nurse will also not be able to provide continuous care if a labor extends beyond the time limits of the shift. Finally, some nurses are not aware that many laboring women want and need continual support. Therefore, they only provide continuous care if there are medical indications (e.g., the woman is receiving oxytocin stimulation). From the woman's perspective, even if the nurse is present for much of the labor, she is not a known individual, and reciprocally, knows little about the woman's wishes or desires for the birth. Therefore it is difficult, if not impossible, for the woman to award that nurse her implicit trust and rely on the nurse to make decisions on her behalf.

This study points to a need for a new approach to maternity care. The type of continuity that is so important to childbearing women is not being offered by a system in which the woman may be cared for by a family doctor, an obstetrician or two, and a number of residents, medical students, and nurses. One alternative is independent midwifery services. With this model, two or three midwives in a practice share in the antenatal care of each pregnant woman. The woman comes to know these caregivers well and is assured that one of these known individuals will be a constant presence with her through labor and delivery. Then, one of these same midwives will continue to provide care during the postpartum period. This model gives the woman an opportunity to build a relationship with her caregivers prior to labor, and be supported through labor by

someone who is known and trusted. The woman can feel comfortable in the knowledge that this caregiver will not leave part-way through the labor, at a time when a woman's need for continuity may be the greatest.

## CHAPTER 6

### **Nursing Implications, Limitations, and Summary**

The results of this investigation have implications for nursing practice, nursing education, and nursing research, and more broadly, for health care in general. At the present time in Newfoundland, and indeed, all across Canada, our health care system is undergoing tremendous change. There is an urgent need to find more cost efficient methods of delivering effective health care to the people of this country. There has also been increasing recognition of the necessity of involving the public in the determination of health care needs and how these might best be addressed. The special health care requirements of women have, until recently, been largely ignored by researchers, and have not been adequately addressed by a primarily male-oriented medical system. As increasing numbers of childbearing women voice dissatisfaction with traditional obstetric practice, it is appropriate that providers identify the type of care these women do value during pregnancy and birth. It is also necessary for governments and health professionals to examine alternative methods of obstetric service which are cost effective and which speak to the specific needs of this population.

#### **Implications for Nursing Practice and Nursing Education**

It is evident from the research findings that participants valued highly the constant presence of a known and trusted individual, someone who remained with them throughout the labor and delivery process. Although with today's

system of obstetric care, it is difficult for the labor and delivery nurse to be known to the woman prior to the onset of labor, it is possible for the woman to receive more continuity of care than is presently being realized. In most hospitals, labor wards are staffed like medical or surgical units, according to an expected average patient census. However the typical labor ward census fluctuates much more widely than other hospital units which, unfortunately, can lead to times when the provision of continuous support by trained staff is impossible. Labor ward nurse managers need to lobby for changes in this approach and adopt more flexible methods of staffing which allow for a trained support person to be with the woman constantly or at least for the majority of her labor, if this is what the woman wants. Obviously one must take into consideration previous studies which suggested that women do vary with regards to their need for the constant presence of a nurse during labor (Mackey & Lock, 1989; Mackey & Stepans, 1994). Therefore it would be important for the nurse to include the woman's need for support in all initial and ongoing assessments as part of the usual plan of care. However, staff nurses must acknowledge that constant support is important for many laboring women, and must not restrict the provision of continuous care to only those women who have medical indications necessitating such care (e.g., women with high risk pregnancies, those receiving epidural anesthetic or oxytocin stimulation).

Accompanying changes in staffing patterns, it would be appropriate for nurse managers to implement in-services for the labor ward staff. Study participants recounted numerous incidents that indicated dissatisfaction with the care received from the nurses and doctors they encountered during their birth experiences. Caregivers must increase their awareness of the special needs of

childbearing women, such as the desire to participate in decision-making and have their decisions respected, the need to be kept informed, and the need to feel the person caring for them will be an advocate on their behalf. Nurses must ensure that women are kept informed of all aspects of their labor and not just those that the professionals think they should know about. This may mean conducting patient teaching themselves or requesting that a doctor speak to a client and her family about a specific procedure or the progress of the labor. Similarly, the woman and her significant others should be consulted regarding all aspects of care, not simply informed of a decision once it has been made by health care personnel. Nurses have to realize that, ultimately, it is the woman's baby and the woman's birth, and the nurse's main role should be to assist that woman to have as positive an experience as possible. This will not always mean medicating a woman as soon as she has pain, or augmenting her labor with oxytocin to speed up the process. Instead, a nurse should take the time to find out about the hopes and desires each woman brings to the birth. The nursing care given can then be tailored in order to sustain, encourage, and enable a woman to reach her goals for an optimum birth experience.

Developers of maternal-child content in basic degree programs should ensure there is an emphasis on the emotional and psychological needs of childbearing women, in addition to content which focuses on physiologic changes during pregnancy and potential disorders. Post-basic obstetric courses, which often focus mainly on technical aspects of maternity care, need to include content directed towards enhancing students' understanding of normal childbirth and the importance of support to laboring women. Nurses trained at the basic level should be encouraged and supported by hospital management (e.g.,

through flexible schedules, scholarships, educational leave) to complete these post-basic obstetric or nurse-midwifery programs. This would augment their skill as practitioners, but also expand their understanding of the meaning of childbearing to the pregnant woman.

Obstetric nurses and nurse-midwives must find a way to provide women and their families with more innovative programs that better meet their needs during pregnancy, childbirth, and the puerperium. One such idea would be a 24-hour phone-in program for new mothers, staffed by a designated group of postpartum nurses who have received additional training and who are committed to the idea of providing home support and education. Considering the present system, whereby public health nurses may visit a new mother only once, this type of program would increase a woman's access to professional advice throughout the puerperium. Perhaps not all new mothers need a visit from the public health nurse, and such a phone-in system would permit these mothers to be screened out. This would offer a way of maximizing health care resources while ensuring that those in need received appropriate assistance.

MacKinnon and MacKenzie (1993) discussed the birth center projects which were in operation in Ontario. These centers were staffed by nurses and nurse-midwives working in conjunction with the woman's physician. Many of these nurses worked flex hours, organizing their time so they could accompany the laboring woman to the birth center and remain with her until after the birth. This allowed much more continuity of care than the traditional hospital approach. Finally, nurse-midwifery care, particularly in the form of independent practice or a birth center approach, should be an option made available to the women of this province who are seeking an alternative to traditional obstetric services.



### **Suggestions for Future Research**

From the present investigation, a number of suggestions can be made for future research in the area of men's and women's experiences with childbirth, with various obstetric caregivers, and with other patient roles apart from those associated with childbirth. Because the participants in this study were all middle class, Caucasian women, it is important that future research investigate the experiences of women from other cultural and socioeconomic groups to determine if the type of care and support as identified in this study would be important to them during pregnancy and childbirth. Research exploring fathers' experiences with midwives would offer insights into the broader needs of the expectant couple, as opposed to only those of the pregnant woman. Although participants in this study were able to speculate on the beneficial effects of midwifery care for their partners, the true experiences of men were not explored.

In most instances, the midwifery support discussed in this study focused upon the care provided by only one midwife. It would be appropriate for other researchers to replicate this study, examining the care provided by a larger number of midwives, in an attempt to validate present findings.

In this investigation the focus was on women's experiences with midwifery support and not on the care provided by other professionals. Six of the 8 participants had not experienced a birth without midwifery support. Thus it is not possible to speak of these women's experiences with midwives, who were known throughout pregnancy and birth, compared to, for example, women's experiences with labor and delivery room nurses, who were strangers at the time of entry to hospital. This, however, could be the focus of a future comparative

study, particularly if participants could be recruited who had experienced a birth with and one without, midwifery support.

Much quantitative research has been completed in the past which examined the relationship between women's satisfaction with the birth experience and the amount of control they perceived they had over birth events or of self. The findings of this study indicate that there is probably more to the issue of control than has been originally thought. The study participants indicated that there is a desire to maintain self control, to participate in decision-making, and to maintain some degree of control over events in the environment during labor and delivery. Yet there is also a need to let go of many conscious, deliberate processes and instead, focus inward and be carried along by the incredible power of the labor process. In addition, when a known and trusted caregiver is present, the women felt comfortable to hand over a certain amount of control to this individual. This was not actually viewed as giving up control however, as this person was seen as almost an extension of self, someone who was acting on the woman's behalf. Even to take the advice of this individual, for example, was the woman's own decision, and not something forced upon her. Thus it may be appropriate that the findings of this study be utilized in revising quantitative tools used to measure control and satisfaction during childbirth.

Finally, the idea of buffering, a predominant theme in this research, is an area which merits future investigation. It is possible that anyone who assumes a patient role desires a buffer, someone who will negotiate on their behalf with other health care providers and who will increase their chances of a safe passage through the system. Therefore there is a need for qualitative research

which explores the experiences of individuals who have assumed other patient roles within the health care system.

### **Study Limitations**

The researcher utilizing a phenomenological method of inquiry relies upon the participants' ability to reflect upon and describe their experiences in order to obtain rich data for analysis. As a consequence of this, the participants in phenomenological research tend to be "the most articulate, accessible, or high-status members of their groups," a problem Sandelowski (1986) refers to as "elite bias" (p. 32). Although it is not the aim of phenomenology to generalize results to the larger population, it must be noted that the participants in this research were all Caucasian, well-educated, middle-class women. Women of other cultural and socioeconomic groups, women who did not speak the language of the researcher, and women who had mental or physical disabilities that would impair their ability to articulate their experiences, were not included in the study. It is quite possible that the experience of midwifery support would be different for these women.

A second limitation is the fact that all but two of the women had encountered only one, and the same, midwife. It could be that some aspect of this midwife's character, her age or her personality for example, might have been a major factor influencing how these women experienced midwifery support. Cross-validation, using the experiences of women cared for by different midwives, could further support or dispute the essential themes highlighted in this study.

## **Summary**

The primary question addressed in this study was: What is it like for a woman to be supported by a midwife throughout pregnancy, labor, delivery, and the postpartum period? The phenomenological approach as proposed by van Manen (1990) was used by the researcher to explore this question with 8 women who had utilized midwifery services for at least one of their childbirth experiences. Two in-depth interviews were conducted with participants, and 3 of the women were interviewed a third time in order to validate themes identified by the researcher. From the interview data, nine themes were identified: (a) midwife as ideal mother, (b) midwife as buffer: ensuring an optimum birth experience, (c) continuity in the midst of fragmentation: the midwife as a known constant, (d) presencing, (e) intuitive knowing, (f) seeking safe passage through the expertise of the midwife, (g) seeing the whole: the woman as part of a family, (h) maintaining control while letting go, and (i) midwife as trusted and trusting.

It was determined from these themes that the meaning or essence of the women's experience was that the midwife was seen as an essential and irreplaceable dimension of the birth experience. A discussion of the findings, including the relation to previous literature, was presented, as well as the implications of the findings for nursing practice, nursing education, and nursing research. Finally, the limitations of the study were addressed.

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**Appendix A**  
**Letter of Request to Mrs. K. Matthews**

Box 126, RR 1,  
Paradise, Nfld.,  
A1L 1C1

August 3, 1995

Mrs. Kay Matthews,  
Assistant Professor,  
School of Nursing,  
Memorial University of Nfld.,  
St. John's, Nfld.

Dear Mrs. Matthews;

As a follow-up to our earlier discussion, I would like to present this written request for your assistance in the identification of participants for my upcoming research study. As you know, I am a student in the Masters of Nursing program here at Memorial, and have just began working on the thesis component of my program of study. I have elected to conduct a qualitative research study, using the phenomenological approach proposed by van Manen (1990). The title of my proposed investigation is **Women's Lived Experience with Midwifery Support During Labor and Delivery**. My proposal has already passed successfully through the Human Investigations Committee at Memorial.

I will need approximately ten participants for this investigation, who have been coached through labor and delivery by a trained midwife. I plan to conduct between one to three tape-recorded interviews with each of these participants,



either in their own homes or in some other location that is preferred by the participants. I would like for you to identify ten appropriate participants from the population of women whom you have coached through labor and delivery in the past. I would then ask that you make the initial contact with these women, informing them of the study and requesting their permission for me to contact them to inform them of the details of the study and obtain consent.

I have included a copy of the inclusion criteria for participants at the end of this letter. Please do not hesitate to contact me if you have any questions regarding the above request. I can be reached at 895-3812. Thank you very much.

Sincerely,

Robyn Beaudry

**Inclusion Criteria**

Participants will be selected based on their having had the experience with the phenomenon under consideration, i.e., having been supported through labor and delivery by a trained midwife (K. Matthews).

There is no limit as to the amount of time which has passed since the woman gave birth, however more recent new mothers (e.g., past 2 - 4 years) are preferable.

Approximately 10 voluntary participants will be chosen on the basis of the following criteria:

- (a) must be able to speak, understand, and read English,
- (b) must be mentally competent,
- (c) must be able to verbalize their feelings and emotions,
- (d) must live within 100 km. (approximately one hour's drive) of the city of St. John's, and
- (e) must be over 18 years of age.

## **Appendix B**

### **Telephone Guide**

Hello Mrs. \_\_\_\_\_ ? My name is Robyn Beaudry. I believe Kay Matthews had told you I would be calling (pause for reply).  
If you have time, I'd like to take a few minutes to explain my research to you and ask for your consent to participate (pause for reply).

I am a student in the Master of Nursing program at Memorial University, and I am conducting research investigating women's experiences with midwifery support during labor and delivery. I hope to talk to about ten women about their experiences. The research would involve conducting between one to three interviews with each woman. These interviews would be tape-recorded, and I also may take a few notes if necessary during the interview. The first interview may be lengthy, about one to two hours, as the woman tells me all about her experience with her midwife. If the second and third interviews are needed, they are usually not quite as long. It is likely that I will ask each woman to read a written account of the taped interview that I have transcribed, to ensure it is accurate and truly captures all of her experience. Then a second interview may be conducted so I can ask the woman if she wishes to change anything, or so she can verify that what is written is an accurate account of her experience. Or I may need another interview in order to clarify something the woman said in the first or second interview, or ask her to expand on something she may have only mentioned briefly. The interviews may occur fairly close together, as over a couple of weeks, or may extend longer, over a couple of months. The interviews

can take place in the woman's home or any place else that is convenient (pause in case the woman would like to ask questions).

In research such as this, it is necessary for me to inform potential participants of any risks or benefits that may be involved. I don't anticipate there being any risks to you if you participate, however it is possible that some women may find discussing their childbirth experience to be emotionally upsetting, especially if they experienced a difficult birth or something went wrong during the birth. If this happens to you, you can feel free to discontinue the interview, take a break, or, if you find it helpful to talk about it, you can discuss the event with me. Some women might find the initial lengthy interview time-consuming. You certainly should feel free to schedule the interview at a time that is most convenient to you, or to take a break during the actual interview. It is important for you to know that, even if you initially agree to participate, you can withdraw from the study at any time.

In terms of benefits, there are no major, direct benefits to the participants themselves. However some women may find it beneficial to discuss their birth experience with a non-judgmental listener. In addition, I hope that the things I learn from this research will allow me to make suggestions regarding how nursing care could be improved for all women in labor (pause to allow questions).

There are a few other things I need to tell you about this research. If you agree to participate, I will ask you to sign a consent form during my first visit with you. This indicates that I have explained everything to you and that you voluntarily agree to participate. There needs to be another person present at this

time who can witness your signature. I will give you a copy of the consent form and my home phone number. You can feel free to call me at any time during the research to ask questions, clarify issues, and so on. In addition if you wish, I can provide you with a copy of the final research report once it is completed.

When I write up the final research report, I will most likely use direct quotes from participants to illustrate a particular point or to give the reader an example. If you want, your real name can be used, for example " \_\_\_\_\_ (participant's real name) described her midwife's care during labor in the following way . . . ." Or, you can select a false name, or pseudonym, that you would rather have me use. Once this research is finished, a copy will be placed in the library at the Health Science Center, and it is possible I may publish selections from it. So it is important that you feel comfortable with how you will be represented in the text.

I will maintain confidentiality of information at all times. All written documents such as my list of participants' names and phone numbers, the consent forms, and all transcribed data, will be kept in a locked filing cabinet in my home. This information will be shredded once the research is finished. All taped interviews will be erased once I have finished listening to them.

Do you have any questions you would like to ask me?

Could we arrange a convenient time for us to meet and sign the consent form?

**Appendix C**  
**Demographic Sheet**

Name of participant: \_\_\_\_\_

Code number: \_\_\_\_\_

Pseudonym selected: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Age: \_\_\_\_\_

Birth for which midwife attended (i.e. first, second): \_\_\_\_\_

Number of years since the birth: \_\_\_\_\_

Current number of children: \_\_\_\_\_

Attended prenatal classes (other than those given by Mrs. Matthews)

\_\_\_\_\_

## **Appendix D**

### **Interview Format**

#### Initial request to participants:

I understand that you had a midwife, Mrs. Kay Matthews, with you during your last childbirth experience. I am interested in knowing what it was like having a midwife with you during your labor and delivery. You can share any thoughts, feelings, or ideas that you have regarding your experience with your midwife. There are no right or wrong answers. Feel free to talk about anything that comes into your mind. I do not plan to ask you any particular questions--I want you to tell me in your own words what the experience was like. However I will try to assist you where I can so that you can describe your experience to the best of your ability.

Examples of probes or clarifiers that may be used if needed (e.g., if participants are unsure where to begin, or need help to continue with their description):

1. How did you decide on having a midwife for labor support?
2. What did you believe that having a midwife present for your labor and delivery would offer?
3. Can you describe the relationship that developed between you and your midwife?
4. Can you describe the care that your midwife offered you during your labor? During delivery?
5. Can you give me an example of "X" (i.e., whatever is being discussed)?

**Appendix E**  
**Letter of Approval from**  
**The Human Investigation Committee,**  
**Memorial University of Newfoundland**





# Memorial

University of Newfoundland

Office of Research and Graduate Studies (Medicine)  
Faculty of Medicine, The Health Sciences Centre

July 27, 1995

TO: Ms. Robyn Beaudry

FROM: Dr. F. Moody-Corbett, Acting Assistant Dean,  
Research and Graduate Studies (Medicine)

SUBJECT: Application to the Human Investigation Committee #95-03

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The Human Investigation Committee of the Faculty of Medicine has reviewed your proposal for the study entitled "Women's Lived Experience With Midwifery Support During Labor and Delivery: A Phenomenological Study".

Full approval has been granted from point of view of ethics as defined in the terms of reference of this Faculty Committee.

It will be your responsibility to seek necessary approval from the hospital(s) wherein the investigation will be conducted.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

F. Moody-Corbett, Ph.D.  
Acting Assistant Dean

cc Dr. K.M.W. Keough, Vice-President (Research)

**Appendix F**  
**School of Nursing**  
**Memorial University of Newfoundland**  
**St. John's, Newfoundland, A1V 3V6**

**Consent to Participate in Nursing Research**

**Title:** The Lived Experience of Midwifery Support During Labor and Birth:  
A Phenomenological Study.

**Investigator:** Robyn L. Beaudry

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide to withdraw from the study at any time.

Confidentiality of information concerning participants will be maintained by the investigator. The investigator will be available during the study at all times should you have any problems or questions about the study. The investigator's phone number is provided on the last page of this consent form.

**Purpose of the Study:** The purpose of the study is to explore and describe the perceptions of childbearing women regarding the midwife's role during childbirth. By gaining an understanding of the kind of care that is important to women

during labor and delivery, the quality of care provided to women at this time may be improved and satisfaction with childbirth increased.

**Description of Procedures:** You will be asked to participate in one to three tape-recorded (audiotape) interviews, conducted at your home (or another place which is convenient for you). Initial interviews will last approximately one to two hours. Second or third interviews will be of shorter duration, and may be necessary to confirm or clarify information obtained in the initial interview. In addition, you will be asked to read the investigator's written copy of your interview(s) to confirm that the description contained in the report adequately reflects your experience with your midwife.

**Duration of Participation:** Interviews for each person should be completed within a six month period, depending upon the number of interviews required.

**Foreseeable Risks, Discomforts, or Inconveniences:** Anticipated risks with this study are minimal, however some women may find it difficult to discuss private emotions, a difficult birth experience, or an undesired birth outcome. If this happens to you, then you may refuse to continue with the interview or request that the interview be rescheduled. You may find the lengthy interview to be inconvenient and should feel free to schedule interviews at a time that is best for you, or to take a break from the interview at any time.

**Benefits of Participation:** You will have an opportunity to express your feelings and discuss your birth experience with an interested, nonjudgemental listener.

Some benefits of the study will not affect you directly but may affect other women in the future. For example, by gaining an understanding of the kind of care offered by your midwife that was important to you, suggestions can be made to improve the quality of care offered to all laboring women.

**Liability Statement:** Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigator, sponsors, or involved institutions from their legal and professional responsibilities.

**Any Other Relevant Information:** If the study is not clear, please ask any questions before signing the consent form. If you have any questions or concerns about the study during or after interviewing is completed, please contact the investigator using the telephone number provided on the next page. Study findings may be published and will respect the anonymity of all participants. Results will be available to all participants upon request.

I \_\_\_\_\_, the undersigned, agree to my participation in the research study described.

Any questions have been answered and I understand what is involved in the study. I realize that participation is voluntary and there is no guarantee that I will benefit from my involvement. I acknowledge that a copy of this form has been offered to me.

\_\_\_\_\_  
(Signature of Participant) (Date)

\_\_\_\_\_  
(Witness Signature) (Date)

\_\_\_\_\_

**To be signed by the Investigator:**

To the best of my ability I have fully explained to the subject the nature of this research study. I have invited questions and provided answers. I believe that the participant fully understands the implications and voluntary nature of the study.

\_\_\_\_\_  
(Signature of Investigator) (Date)

Phone Number 895-3812









