DOWNLOAD PDF WHAT I REALLY NEED IS SUPPORT: RELATIONSHIPS BETWEEN WOMEN AND MIDWIVES

Chapter 1 : Women and midwives in partnership: a problematic relationship? | Valerie Fleming - blog.quinto

The relationship between midwives and the women they care for affects women's birth experiences in countless ways - a good midwife-woman relationship can create a positive experience from even the most challenging birth, while a negative one can leave scars that last for decades.

Open in a separate window Data analysis Detailed field notes were kept during the observations and written up in full immediately afterwards. Interviews and focus group discussions were audio-recorded and later transcribed and entered into the computer assisted qualitative analysis package N6. All data and field notes were analysed thematically by the principal investigator and research assistant. Both researchers read the transcripts and field notes several times, identifying minor and major codes and the relationships between them Coffey and Atkinson In order to enhance analytic trustworthiness and rigour this process was undertaken blind, as a form of peer validation. After minor refining of coding categories and terminology, researcher agreement was reached. An analytic coding frame was created and used to code all data. At the end of the study, a project roadshow travelled around Wales to allow early dissemination of the findings to midwives and doctors. An additional purpose of the Roadshow was to test out the analysis during audience discussion and via written evaluation forms. While they are not a formal means of respondent validation, the roadshows do indicate the general credibility of the data. Findings This article focuses on selected findings relating to the effect of the pathway on inter-professional relationships and boundaries. It draws largely on the interview and focus group data, interwoven with fieldwork observations when relevant. Interpretation of the data is informed by sociological understandings of boundary work and how clinical pathways may act at the interface of professional boundaries, signalling the limits of delegated authority. Key themes identified are: The first example of a pathway aimed at promoting normal birth, its ultimate purpose is to reduce unnecessary childbirth intervention Fox The pathway is accessible electronically. For example, it contains a decision-making protocol, informed by research evidence, where available, and best practice where no research base was identified. The pathway also acts as a record of care, in the form of a tick box with written notes made only if there is non-compliance with usual care Hunter and Segrott Firstly, it is unidisciplinary â€" used only by midwives. This removes the challenges â€" and possible opportunities â€" of creating and using a multidisciplinary tool although, as will be seen, other challenges have arisen instead. Secondly, rather than standardising care for a specific condition, the pathway set out to fundamentally change the approach to intrapartum care by creating a tool to implement midwife-led care for all women with straightforward pregnancies. This was achieved by devising clear eligibility criteria demarcating professional boundaries: Increased time was allowed for labour progress so women could remain in midwife-led care for longer. Finally, the pathway was a national rather than a local strategy, embedded in Welsh maternity policy Welsh Assembly Government An intended consequence was the sharper delineation of midwiferyâ€"obstetric boundaries and the increased visibility of midwife-led care. Midwives described the pathway as being supportive of a normal, physiological approach to intrapartum care, enhancing confidence in midwifery knowledge and skills and providing clear criteria for midwife-led care. Unsurprisingly, midwives did not generally describe this privileging of a midwifery discourse as problematic. They described feeling excluded and undervalued. These experiences and the increased inter-professional tensions that resulted were unintended. However, we will argue that conflicts were certainly predictable, given that from its conception the pathway was a professional project intended to promote midwife-led care, and facilitating inter-professional working was never the intention of the pathway developers. A midwifery project from the outset? Although increasing levels of childbirth intervention could reasonably be seen as a problem for all maternity care practitioners, the approach taken in Wales was not multi-professional. A decision had apparently already been made by senior midwives and at a government level: Consequently, some midwife participants argued that it was not really necessary to engage doctors other than in a support role: We needed a

body of clinicians for the steering group and we discussed the balance of midwives versus obstetricians, and the internal reference group â€" the policymakers â€" and [senior civil servant] believed it was a midwifery initiative but that we would absolutely want the support of obstetricians. Interview key informant The eventual steering group composition had a majority of midwives and only one obstetrician member. Other participants commented on this imbalance, and its implications: It would have helped if they [doctors] were more involved in the implementation and the development â€¦ they should have had more than one on it â€" if you want to implement something new, you need to get lots of stakeholders on board. Right from the beginning we disagreed with some of the stuff in there. I do think if you want to get the doctors on board, you need to do more of an effort. This sense of having had permission to challenge a medicalised approach to labour care led to a sense of increased confidence, especially for newly qualified midwives: Focus group 4, Unit A: Interview J, midwife Unit B To legitimise their practice the midwives drew on both the normal birth discourse embodied by the pathway and the discourse of scientific evidence-based practice exemplified by the reference list included in the pathway, which underpinned its guidance: Focus group 5, Unit B midwives This scientific discourse was also described as offering a protective function in relation to interactions with the medics: Why are you doing â€¦? However, it was apparent that the quality of the underpinning evidence was largely taken for granted by the midwives. By contrast, the doctors questioned the robustness of the evidence base: Focus group 1, Unit A midwives Midwives had previously tackled these issues as individuals rather than as a professional group. Focus group 5 Unit B For some midwives the very existence of the pathway appeared to be enough to give a sense of back up. When asked directly, many midwife participants found it difficult to articulate exactly how the pathway achieved this, suggesting it had an almost talismanic quality: Interview N, midwife Unit A Throughout these data runs an image of midwifery as an embattled profession, with midwives seeking permission, protection and back up from the pathway to boost professional legitimacy and exclude those who seek to undermine it. It does give you a little bit of ammunition. Perhaps most importantly, the pathway is a textual representation of midwifery knowledge accessed and used only by midwives. This exclusivity has important implications for establishing an authoritative knowledge base and the exercising of power. In order to define professional territory the scope of the work, its recipients and boundaries must be specified. By identifying some women as appropriate for care solely by midwives the pathway clearly demarcates these territories. What is significant and new here is that it is midwives who instigated this change and individual midwives who decide which women are cared for on the pathway, using eligibility inclusion and exclusion criteria. This is a significant shift in professional authority, as traditionally the categorisation of women in terms of their perceived risk status was undertaken by obstetricians. As the pathway is used exclusively by midwives, the midwife controls access to the client and her clinical records. As one midwife explained: Focus group 1, Unit A midwives Interestingly, few doctors commented on how these initial eligibility decisions were made or on the shift in authority that accompanied them. Midwives used it to emphasise their unique expertise in normal childbirth and to challenge the dominant biomedical discourse: It takes a lot for the midwives to challenge the doctors because they are assumed to have the greater knowledge. Focus group 5, Unit B midwives This exercising of midwifery authority was observed during fieldwork. For example, during one labour a doctor had entered the birth room uninvited and failed to introduce himself â€" both transgressions of the etiquette of midwife-led care. Dr G Registrar comes in to the birth room: Midwives questioned what the impact on these women might be for example, they might now have electronic foetal monitoring during labour when this would not have happened previously. It was felt that a grey area had been created, where women were not low risk enough to meet the inclusion criteria for pathway care but were also not high risk. This problem was compounded when pathway eligibility determined place of birth; for example, a midwife-led birth centre or an obstetric unit. By shifting the parameters of normality the pathway thus had territorial implications for both midwives and doctors. Paradoxically, the increased status of midwifery work appeared to have come at the price of a reduced scope of practice. Shifting medical territory and jurisdiction The doctors described increased tensions in their working relationships with midwives that they attributed to

the pathway implementation, and expressed concerns about perceived shifts in professional authority and its implications, as in the following observation: He fears that there is a hidden agenda behind the pathway â€" that it will lead to centralisation of services, closure of smaller units. This may explain the apparent lack of lobbying to increase medical representation on the steering group. Doctors no longer had automatic access to low-risk clients or their records of care. They expressed concerns that this limited knowledge could prove problematic if medical advice was required: There was frequent reference to boundaries being drawn on the basis of women being on the pathway: Interview J, doctor Unit B The doctors emphasised the value of team-working and how this had been compromised by the pathway: Too many Caesareans is not nice. Interview S, doctor Unit A The doctors also expressed concerns that they had no overview of the overall maternity unit workload, which they considered necessary to plan their working day. The exclusion of the doctors was manifested in the use of the whiteboard. These dissonant approaches are evident in the following accounts. From what I understand, a normal care pathway means that this patient is presumed absolutely normal and will have absolutely normal labour, which I have a big reservation about because in labour, even if the patient had no problems before, you never know until the patient is delivered and the placenta is out â€¦ you see the problem with obstetrics is that some of them are very, very dicey and dangerous â€¦ Although the patient is OK at the moment then things can go pear-shaped any time. Although this emphasis on technical skill might be expected, given that obstetricians are the experts in abnormal childbirth and employed precisely because of this clinical expertise, in the view of the medical participants this aspect had been accentuated since the introduction of the pathway. Explaining why the lack of contact with low-risk women was problematic, doctors described their loss of the soft side of care: There is a loss of that relationship [with women] and also the loss of being present with more normal deliveries. If you want doctors to be holistic practitioners, then you should give them a chance â€" we have been pushed into this technical area. This in turn affected inter-professional relationships between midwives and doctors, with the clinical pathway acting at the interface of professional boundaries by signalling the borders of delegated authority. It achieved these changes in three key ways. Firstly, it was used by midwives to delineate spheres of professional practice and the boundaries between them. Even though the pathway did not fully involve doctors, they were part of its overall structure and it is therefore not surprising that it affected their roles and identity. The development of the pathway thus comprised key characteristics of a professional project that have been identified in the literature â€" the seeking of autonomy and the attempt to achieve occupational closure over an area of practice Evans , Witz The pathway sought to achieve this closure by drawing a clear boundary between the sphere of normal labour the expanded domain of midwives alone and high-risk labour that required the medical and technical expertise of obstetricians in collaboration with midwives. Rather than adopting a collaborative approach from the outset, with both professions discussing possible joint solutions to a shared problem, engagement with doctors was minimal. Indeed, the data suggest that doctors were frequently seen as part of the problem, not part of the solution. Moreover, this approach failed to acknowledge that medical participation would sometimes be clinically necessary. It is likely that this fundamental gulf in the social meaning of the pathway for all concerned led to the increased inter-professional tensions identified in this study. Pathways are not ideologically neutral. Instead, they are socially and professionally constructed and draw on specific kinds of knowledge and belief systems Berg

Chapter 2 : â€˜Making a differenceâ€™: midwivesâ€™ experiences of caring for women | RCM

Studies show that what women remember after birth is the emotional support they received from midwives (Waldenstrom,). A midwife who is not confident in herself will not be able to promote a high-quality relationship (Rogers,).

This article shows, however, that the beliefs which underpin the practice of the midwives are not always the same as those of their clients. Supporting evidence is provided in the form of verbatim data provided by participants. Three major areas in which contradictions were found were in the work of midwives, the knowledge for practice and reflections on the experience. It is recommended that midwives become more visible by removing themselves from hegemonic structures, valuing alternative forms of knowledge and respecting the knowledge of their clients. The 12 midwives in this study worked out- a number of innovative approaches to practice both in side of the hospital system but received payment for ser- hospital and community settings. Clients, therefore, received The enactment of the new legislation was in part due to midwifery services free of any charges other than normal the combined efforts of both midwives and consumers who taxation. Prior to the research being undertaken none of together campaigned throughout the late s for mid- the midwives were personally known to me. The initial wifery autonomy. Since this spirit of partnership has contact was made through midwifery and nursing col- continued to exist and has been ratified by the constitution leagues and when later approached with the completed of the New Zealand College of Midwives. However, while research proposal the midwives appeared very interested the notion of partnership has the potential to foster healthy and keen to be involved. Seven had children of their own. All were This article provides data from a 3-year research project registered nurses for varying lengths of time prior to which investigated the relationship of midwives and con- becoming midwives. Experience in midwifery practice sumers. It focuses on some of the contradictions apparent ranged from 20 years to just over 2 years. All were committed to a midwifery Following such approval, data were collected primarily model of practice which was woman-centred in its focus. With per- the independent midwives for all or some of their mission each of these was taped and transcribed verbatim. The data presented below approached by the midwives who told them briefly about have mainly been drawn from the individual interviews. Following this discussion, the women agreed to Sandelowski suggests that there is no reliability coef- participate in the preliminary meetings and subsequently ficient which can deal adequately with the analysis of quali- the research itself. Two women were single and three were expecting developed and maintained at that time. By thus illumin- their first babies. One woman separated from her husband ating new possibilities for action, readers are offered a early in the pregnancy, before her involvement in this surrogate experience. Identification of similarities and dif- research. Two of the women had previous experience of ferences may allow readers to engage in critical reflection midwifery care when they were followed-up by com- of the conditions of their own practice and so enhance munity midwives following early discharge from hospital. There is therefore a continually All were attending independent midwives for the first evolving process, with constant potential for action. Twelve of the women were also having some The validity of this research and the critical theories pre-natal care from their general practitioners. In this study, data I came into this study as a midwife with 14 years mid- from interviews with midwives were compared with those wifery experience in a variety of settings and in several from clients; journalling and clinical notes used to sup- different countries. Most of this experience was in hospi- plement interviews and videotapes of some of the births tals dominated by the medical model of obstetrics, but in added further means of triangulation. Previous research in the theory was changed by the logic of the data. However, as with construct validity, some of these effects The collaborative nature of this research implied the are not immediately visible, but may become so with the affirmation of the rights of individuals to autonomy and passage of time. The work of midwives Prior to commencing this study the research proposal was presented to, discussed with and approved by the Midwives in this study were

concerned with defining how University Human Ethics Committee. Following this partnership was important for them. Fleming As well as doing all the physical checking of pregnancy, I see it knowledge and experience and knew about different herbs and as learning to be a support person. I think they should be doing at all. And I do that to an absolute minimum. I trician last time. I just The scenarios outlined above represent a different situ- need the reassurance of being checked out. However, it is not to say that the work of mid- their clients, in general the hospitals in which they prac- wives was not appreciated by their clients. However, passivity expressed by the women in the However, while the midwives in this present study saw excerpts above is not a feature of all women. Some women themselves as dismissive of such ways of practising, the choose to participate in their care to an extent which is clients presented different views of midwifery practice. Just to make sure everything is progressing the way it should be. And everything was on her terms, and she lived away out of the city and was due in the middle of winter. She felt that all antenatals obstetrician. Yet is with the However, the client in this instance saw the issue some- aim of moving away from the medicalization of pregnancy what differently from the midwives, creating another that midwives advertise their services. This was stressed contradictory scenario. I mean my husband works on so hot and stuff like that you know, and not having to sort of look shifts and I would have to find someone to care for the children this way and act the part. As demon- judgement on knowledge which does not come from strated above, this study supports these views though who traditional Western epistemologies. Here, post-modern holds the power is called into question. In situations such thought which rejects the dualisms of the Enlightenment as this it has been suggested that when powerful hegem- is useful. While the above power of the written, dominant discourses over the examples alone cannot be seen to be indicative of new spoken. However, while the mid- maternity services more generally. Women have been socialized into believ- the spoken word were also clearly evident when clinical ing that their doctor would take charge of the whole experi- records were examined. Likewise, some women in All progressing normally. Slight swell- this study had similar experiences in previous pregnanc- ing of ankles in the evenings. Advised to elevate feet when sitting ies. The legislative changes of , however, permitted down. Blood pressure slightly down at times. See again in two these women to seek alternative forms of care, one of weeks. Yet in the first interview I had with this client, she gave a The midwives in this study outlined in a group session very clear picture as to why she preferred a female primary how they felt that their specialist knowledge as midwives caregiver: They do not have which were mutually beneficial, so that each was able to those life experiences. They can empathize and in my belief they grow and learn from the experience. But they can and that is possible. This excerpt substantiates the difficulties felt by feminist Contradictions were also expressed by midwives and philosophers who argue for recognition of ways of know- clients in relation to their expectations. Midwives gener- ing which are outside the parameters of male thinking ally expected clients to articulate their wishes for the birth which have dominated the Western world since the time in particular. Midwives, in I always begin at our first meeting after the introduction by asking attempting to practice within a framework which is differ- a woman what she expects from me. Fleming Some days I think I know what I want but on others it becomes the doctor, who was providing shared care, such an lessâ€¦ certain. Surprisingly, this woman welcomed this examination because, as she stated, it allowed her to know how much However, midwives in this study have stated: What it did not do however, was However, we do get women less sure of what they want who are give her any indication of how long she would have to go sent to us by their friends. The midwife describes the same occasion: And often quite impressed with. And that gives us VE. And so, but active in labour? Vitamin K how about an injection? It was just what she needed. It just seemed to take describes as a fairly common problem, discrepancies the edge off them so that she couldâ€¦ it knocked them back a bit, between goals of two groups. One midwife recognized this: Here, however, not straightforward and in the future may offer a forum for the relationship of midwife and client was not strong discussion amongst midwives and clients. It is described by one of the clients who reflects on her experi- the singularity of this approach which needs to be rejected ences during her labour, during which time, although she by both midwives and clients for progress to be made in had been in hospital

for 2 hours with her midwife in the development of a midwifery model of practice which attendance, she had not had a vaginal examination to is recognized as different from the medical model. And the doctor had to see, he wanted to know where you are. It Reflecting upon the experience was quite good though. In this study rich data were obtained from these people and in some cases videotapes of the birth provided During the pregnancy this client and her midwife had further sources of data. However, on the arrival of given below. I wanted it to go away completely. I actually that time. If midwifery was It was a dilemma. Unfortunately I think midwifery really. I needed some direction and they just sat back doing nothing. It really upset me. I totally lost it. She was great so much in control. This section considers the relevance of described as supportive of the woman and participative as the findings for midwifery practice in New Zealand and required Barrington , Rothman It is also the elsewhere. The extent to client has of her body and the changes occurring therein. While it is evident that there is still some work to be It is not surprising, however, that these midwives and done the contradictions felt and expressed by one midwife clients were able only to partially surface the social con- and one client had positive implications for that client. Despite the legislative changes, established It was amazingâ€¦ it was just soâ€¦ soâ€¦ womanly. I mean there was knowledge structures are firmly embedded and communi- me, the midwife, the doctor and my woman friends. It was lovely, cated in everyday practices. Yet, by reinforcing such so much better than my other experiences. I think all births should beliefs, midwives continue to perpetuate their own pos- be like that. A third degree with its androcentric knowledge base and detailed tear, I just feel so terrible.

Chapter 3 : 5 Ways to Choose Between an Obstetrician and a Midwife - wikiHow

The redevelopment of this personal professional relationship between women and their midwives is an important step in the humanization of birth and has never been more necessary.

Posted on June 28, by midwifethinking When I facilitate workshops with midwives and students, there is always a lot of discussion and debate about professional responsibilities in the mother-midwife relationship. Please note that this post is aimed at registered midwives ie. It is also about Australian midwifery and may or may not be applicable to other countries. So, it can be helpful to reflect on what our core responsibilities are in the mother-midwife relationship, and how we can meet them. In this post I discuss my interpretation of these documents and the law in relation to responsibilities. I would be interested in your interpretations too so please comment. It is essential that midwives provide women with adequate information. In Australia, private practise midwives can withdraw care if a woman declines consultation or referral. In the case of a procedure â€" the person performing the procedure needs to gain consent ie. For example, if a midwife is about to start an induction process for a woman â€" that midwife is responsible for ensuring the woman is adequately informed. In addition to this offer, the woman needs adequate information to consent or decline the offer. For an option or intervention adequate information includes: The rationale for the recommendation: A description of the option or procedure: General benefits and risks of all options: NMBA offer further guidance stating that: Midwives refrain from engaging in exploitation, misinformation or misrepresentation with regard to health care products and midwifery care. What a woman needs to know about induction of labour for post-dates pregnancy: I can see that some of you are already cringing, but this is the truth. You also need to quantify that risk for the woman in a meaningful way eg. What induction of labour involves and how it is different to physiological labour; and what would happen if she chose to wait eg. The individual risks for the woman i. Are there other health concerns or issues eg. What a woman needs to know to consent to a routine vaginal examination during labour as per a hospital guideline rather than in response to a situation: It is particularly important to provide clear information when a woman is making decisions outside of recommendations or the norm. In order to do this she needs to have adequate information. For example, if a woman is choosing to birth at home she needs information about the benefits, risks and other options. She needs know the difference between home and hospital, including how the setting might alter the management of any complications. Information sharing needs to be documented. Like any aspect of care there needs to be evidence that it happened. Some hospitals are using consent forms for common interventions eg. VE and ARM with a list of risks for the midwife to read out and get the woman to sign. If you give the woman any information resources â€" write down what you gave her. This involves being honest with women about your experience and ability to meet her needs. Safety is in the eye of the beholder â€" it is up to the woman whether she thinks a 1: Which brings us to the issue of bias. Information sharing needs to be unbiased, and this is extremely difficult because we are all biased and have our own beliefs and opinions. However, there are some strategies to avoid transmitting your bias whilst giving information: Present both sides of the coin see above ie. Ensure that the woman knows you are not invested in her decision, and that you do not want to influence her either way â€" say this to her. Avoid telling her what you did with your own pregnancy, birth, baby â€" again, this is not relevant to her. Not only can this influence her decision, but it can also make things problematic if a transfer to that hospital is needed. A good way to assess whether you are providing un-biased information is to look at what women in your care choose to do. If all of the women you care for choose the same option â€" you need to consider if you are influencing them. Women are individuals and there should be a range of decisions being made. For example, if a woman declines the offer of a vaginal examination â€" you simply document her decision and carry on. You may need to let colleagues know what her decision is and ensure that they respect it. In some settings you may be question or pressured about her decision â€" but ultimately you are fulfilling your legal responsibilities regarding consent. This trumps any institutional cultural norms or expectations.

Midwifery care is holistic in nature, grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women and based upon the best available evidence. For example, competent management of an emergency situation will be different in a home setting compared to a hospital setting. However, if midwives meet their responsibilities above , then women become accountable for their decisions and the outcome of their decisions. Many factors influence decision making, and the information a midwife provides is only one piece of the puzzle. We often start with a conclusion, then rationalise it with evidence. Midwives cannot, and should not take responsibility for the sources information a woman chooses to engage with. Most women will be influenced by the mainstream risk discourse and cultural norms. Women who make decisions against this discourse must seek information and people who will support their decisions. Some do this in response to previous experiences with the medical paradigm. Outcome of Decisions ICM a state that women should accept responsibility for the outcomes of their choices if the midwife met her responsibilities. This is not about blame. It is about accepting that an outcome good or bad directly associated with a decision is the responsibility of the decision-maker.

Chapter 4 : Doctors Suck, But So Does Your Midwife - Indie Birth

The need to establish a relationship with women was a priority for many of the midwives interviewed, and considered an important starting point in the midwife-woman interaction: 'There are certain things that you do like checking her over.

And being in the business of rabble rousing and questioning the status quo, many of these women who seek us out are unhappy with the care they received from their midwives, not just OBs. There are plenty of variations on the same theme. Midwifery care feels just as cold and clinical as OB care, just with a rocking chair and some nice music in the background. I hear stories, get emails, talk in person or on the phone to these women. They thought that they were hiring a midwife, and that meant they would get holistic, evidence based care, and flexible care that was woman centered. Well, they were wrong, and they are pissed. But it bears repeating, and maybe more articles means more women find this. Midwives are not all the same. It is an unfortunate reality that you cannot trust someone to help you in a woman centered way just because they are a midwife. If you think you found an awesome midwife, you still need to put on your sleuth hat and do some serious digging. An awesome midwife who will support and serve you however you see fit will have no problem with you asking questions and giving her the 3rd degree no pun intended birth nerds. An awesome midwife will be GLAD you are asking questions and taking responsibility for your own experience. She will want you to be sure that she is the right fit. If you interview with a midwife, she should give you the names of all the other midwives in your area and encourage you to interview with them too so you can find the best fit. Without that, what do midwives think they are doing? How do we make this clearer to these women? None of these has worked particularly well. What do you think Indie Birth mamas? What brought you to the dark corners of the internet to find us? Is there something that could have, or did help you see through the smoke and mirrors of modern midwifery?

Chapter 5 : Responsibilities in the mother-midwife relationship | MidwifeThinking

Women need to feel uninhibited during childbirth thus, some preferred their husbands as support persons because of the intimate relationship [44, 45, 54] as well as close female relatives or friends [46, 47, 50, 53, 54].

Sometimes, the impression is that you need to choose either a midwife or a doula, or that you do not need a doula if you have a midwife. Both medical doctors and midwives are covered by MSP as maternal health care providers. Doulas fill an additional role, and work as a complement to the care provided by your doctor or registered midwife. In Canada, midwives are licensed medical professionals. Vancouver Midwives are able to attend both home births and hospital births, and are responsible for the health of you and your child prenatally and during childbirth. Doulas, on the other hand, are not medical professionals. Doulas provide emotional and physical support during pregnancy and birth. Establish a prenatal relationship with you Help you articulate your vision for your birth Direct you to resources in the community for pregnant women and families Help keep you and your partner feel calm and supported during labour Use tools and techniques to help you manage the intense physical sensations of labour and birth Make suggestions regarding labouring and birthing postions depending on how your labour is progressing Ensure you feel confident communicating your needs to your health care provider Provide postpartum emotional support and help with breastfeeding initiation. Direct you to your doctor or midwife for any medical questions. Although doulas do not provide medical care, research shows they do increase your likelihood of avoiding unnecessary medical interventions such as instrumental delivery and cesarean birth. Doula support is an amazing complement to the care you will receive from your midwife. There are many amazing midwives here in Vancouver, and they certainly provide great support for your birth. However, their ultimate responsibility is the health and safety of you and baby. They need to be present, alert and at the top of their game during really active birth and pushing. Your doula will stay with typically join you earlier than your midwife, from as early as you would like her there until after the birth of your baby. We love being part of early labour onward. That continual support makes so much difference! Also, here in Vancouver, midwives work in teams of midwives. You will have a chance to meet all of the midwives on your team during your prenatal visits at least once, but there is no guarantee of which midwife will be on call when you begin your birth process. Most doulas are contracted as individuals, and a back-up is only called in in case of an emergency or overlap of births. If you are looking for birth professionals who view pregnancy and birth as a normal, natural event, using both a midwife and a doula will give you the full spectrum of support and medical care you need. However, they are different professions and you will need to select your midwife and doula separately. Heres how to find your own midwife and doula in Vancouver: To find a Vancouver Midwife: To find a Vancouver Doula: Lots of great options for narrowing down your doula search in Vancouver, or contact me to set up a free consultation and interview: Click here to find out! Subscribe to get more: Join other mothers and birth professionals on my mailing list!

Chapter 6 : Midwife / Client Relationships - from Ronnie FalcÃ£o's Midwife Archives

Some women want a supportive practitioner who will listen to their concerns and offer emotional support; others prefer a more businesslike relationship, seeking emotional support from other people, like their partners, friends, and family members.

A grounded theory approach used data collected from individual interviews with 14 NHS midwives, who volunteered to participate and represented a range of midwifery experiences in differing NHS practice settings. The midwives felt a responsibility to be in control, but often felt that others had taken over that control. This led to negative experiences, dissatisfaction and frustration when they felt powerless to help women have a satisfying experience. Midwives working in a large bureaucracy like the NHS may feel impotent and unable to support women consistently in achieving their goals and expectations. There are implications for the learning experience of student midwives, and the next phase of the project will explore the experience of midwives working outside traditional maternity services as a means of comparison. Midwifery, woman-centred practice, grounded theory, educational strategy Introduction This paper reports on the first of a four-phase project aiming to develop an educational strategy to enable midwifery students to become woman-centred practitioners. It stands on its own in discussing the research findings of this phase, focusing on the experiences of midwives working within the NHS. However, it will also be used to inform the final findings of the entire research project. The broad areas addressed in this paper are: Attempting to identify more effective means of midwifery learning and teaching in order to facilitate development of womancenteredness may be optimistic, since the limitations of education as a means to social change are recognised. However, it seemed worthy of exploration as the potential benefit could be significant to childbearing women as well as to midwives. Literature review An educational strategy should be based on sound evidence. Were there other concepts that also needed to be included if students of midwifery were to develop woman-centred knowledge and skills? Sources included empirical research and opinion papers, as issues were sought that appeared important to both researchers and writers in midwifery. To this end, diverse local, national and international midwifery and childbirth literature was explored. The choice of concepts was derived by the frequency with which they appeared, the numbers of writers expressing them and the strength of discussion. Two overarching themes ran through this literature, one relating to the medical perspective of birth and practice and one to a more social view. Medical perspective Medicalisation is a sociological term that suggests there is an increasing tendency for medicine to expand its claims over what would have historically been considered social phenomena Hillier, Many authors recognise the effect of medicalisation as disempowering for women Davis-Floyd, ; van Teijlingen et al, , and routine or indiscriminate use of interventions is considered to worsen some birth experiences Anderson, a; Davies, ; Murphy-Lawless, For many, the need for midwives to act as advocates for women in order to keep birth normal is a priority Fahy, ; Page and Sandall, ; Righard, Evidence-based practice EBP may be a tool to hold back this tide of intervention if evidence from diverse sources is recognised as valid. Limiting the scope of evidence used to inform practice may simply perpetuate the medicalised approach to care rather than offer tools to challenge it. Discussions about risk can effectively disempower women by making them feel it necessary to comply with medical opinion in order to keep themselves and their unborn babies safe Dodd and Newburn, ; Thomas, It is another significant factor that affects the way women experience and see childbirth, focusing on medical complication rather than the social norm. Social perspective The relationship between midwives and women appears to be a key concept that is extensively discussed in the literature. A variety of dimensions to the relationship are explored, including reciprocity Fleming, , the notion of the professional servant Cronk, , moving beyond professionalism Wilkins, and the element of trust Anderson, b. Continuity of care and carer has been a hot topic since the first small team midwifery project was studied by Flint et al There are numerous studies that highlight the advantages to women of knowing the midwife who provides her care Walsh, ; Page et al, ; McCourt and Stevens, as well as

two systematic reviews on continuity schemes Hodnett, ; Waldenstrom and Turnbull, Criticisms remain despite this evidence, largely in respect of the personal commitment required by the midwife Farquhar et al, Finally, issues of choice and control still appear frequently in the literature, highlighted originally as crucial in maternity care in Changing childbirth Department of Health, and since adopted more widely in the NHS in terms of patient choice Department of Health, Feeling in control is said to increase satisfaction in the childbirth experience Bramadat, and information with which to make choices is crucial Lovell, ; Berg and Dahlberg, ; Lavender et al, However, the medical discourse commonly used in maternity care can disempower women as it puts the practitioner in control and may exclude women from understanding key issues Leap, ; Hewison, Much of the literature reviewed was empirical, based on research findings. But a considerable amount was also based on opinion and some of those opinions would benefit from further exploration. In order to find an explicit theoretical base on which to build an educational strategy, there appear to be more questions that would benefit from investigation. Its purpose is to explain a given social situation by identifying the core and subsidiary processes operating in it Baker et al, Sampling is initially selective with participants being chosen based on their experience relevant to the phenomenon being studied. Once initial data collection has been conducted and themes and categories begin to emerge through concurrent analysis, the researcher undertakes theoretical sampling by selecting specific data sources to discover variations in the situation Baker et al, These categories are pursued until no new concepts emerge from the data. This phase of the project involved individual interviews with 14 midwives who worked in the maternity unit of a district general hospital in south-east England. The unit had a team approach to midwifery care at the time, and some of the participants were team midwives seven , some were core staff five , one was a midwifery manager and one a link lecturer. Ages ranged from 29 to 50 years, and experience as a midwife was between one and 27 years. Ten of the midwives had trained in south-east England and four elsewhere in the UK. They were recruited on a volunteer basis, the head of midwifery supported the study and the opportunity to be involved was advertised in the unit. Participants were given an explanatory letter as a means to gain their informed consent, they were assured of anonymity and confidentiality in the reporting of the findings and offered the opportunity to stop the interview at any time. Ethical approval had been granted by the local research ethics committee prior to data collection. The interviews were conducted by the researcher and, in all but one case, took place within the maternity unit. Each lasted between 45 minutes and one hour, and were recorded and transcribed verbatim. It represents the operations by which data are broken down, conceptualised and put back together in new ways, or the restructuring of the phenomena, in order to attach meaningful names or codes and subsequently to develop categories and themes from the data collected. The first interviews were semi-structured, with a few prompts used to generate stories and discussion. As codes and categories developed, these provided the focus for discussion in subsequent interviews. The validity of the research was tested in a number of ways throughout the project â€" by presenting aspects of the unfolding analysis to colleagues in seminars and at conferences, through discussion with supervisors and researchers in the field and by testing themes with student and qualified midwives informally. The feedback from these sources was included in a reflective diary that recorded how external sources helped make sense of the data. Discussion of findings Coding led to the identification of categories, and ultimately of three themes see Figure 1. The numbers used to identify the midwives in this section reflect the order of interviews. Making a difference The three categories identified in this theme intertwine, and all relate to midwives connecting with women beyond the physical support and care required in pregnancy, labour and birth. Building a rapport The need to establish a relationship with women was a priority for many of the midwives interviewed, and considered an important starting point in the midwife-woman interaction: That is routine, blood pressure, temperature, urinalysis, listen to her baby. And you actually build up a rapport with her and you get to know her. Firstly as a patient and then as a person. This distinction between physical and social activity emulates the roles described by Wilkins â€" that women value significantly personal and emotional engagement with the midwife more than a narrow professional one in which the woman is objectified and the relationship is functional. Similarly, Edwards

found that women defined their need for support from a holistic viewpoint â€" they wanted both physical and emotional support from the midwife. The midwives interviewed in this study identified the importance of both dimensions of care, finding it easier when they had sufficient time to be with the woman, especially in labour. When the pressure of work prevented their continuous presence, they expressed frustration: I felt bad because I had to leave [one woman]. I had to pop in and pop out, pop in and pop out. I kept apologising to her and then the other woman I was with They also found it easier to build a rapport when they had the opportunity to get to know the woman over a period of time, when they could provide continuity of care. Continuity It was not only the team midwives who raised the issue of continuity â€" the core midwives could see definite advantages as well: I did know her antenatally as well and I think that does make a difference. Debates on continuity of care and carer appear to relate more to organisational efforts required to implement or evaluate its effectiveness rather than in challenging its potential to enhance meaningful relationships between women and midwives. It was special At times, the midwives felt that they were able to make a significant difference to the women in their care, and when this happened they appeared to feel very positive about it: But we just danced And then she got up again and we started dancing right up until the head was almost on the perineum. The midwives appeared excited when telling these stories, remembering particular births with positive feeling, and the concept of reciprocity Campbell, in the client-professional relationship appears pertinent. Preparing This theme was described somewhat briefly but emphatically in the interviews as a key role of the midwife. The responsibility to prepare the woman for labour, birth and early motherhood, helping her to know what to expect, was dealt with by giving women advice and by teaching them: The suggestion here and in other interviews was that the advice given by the midwife would help the woman to be prepared for the unknown. However, there appeared to be a reluctance to tell women the truth about the pain of labour or of potential negative outcomes of complications in pregnancy, for example, with respect to pre-eclampsia: The midwives appeared to want to protect women from the reality of the pregnancy or birth experience. This would seem a paternalistic approach to care, where the practitioner sees it as their responsibility to make decisions for clients based on professional knowledge and expertise, then guiding the person to an understanding of why the decisions have been made McKinstry, There was reticence about taking responsibility for this unrealistic picture: Clearly, this woman did not achieve her expectations â€" she had hoped for a non-interventionist birth that did not unfold. Generally, the midwives were aware that it was their responsibility to prepare the woman but seemed unable or unwilling to consistently portray an honest account of labour and birth so the woman could really consider her options. The idea that midwives can actually control the outcome of a pregnancy through their supervision would seem illfounded. In these descriptions, there is a lack of agency to the woman or her body. There is a dissonance between this potential for control and the relative powerlessness expressed about helping women achieve their expectations. Feeling in control Once again, there were positive descriptions of experiences in practice, but these were defined in relation to the lack of interference by anyone else: Because it was really what the person was doing, it really was a normal delivery. She delivered the baby, the woman did. We only actually deliver babies when women have sections. Normally, they deliver their babies. Indeed, the fact that things progressed without a need for any specific action was considered particularly pleasing. These positive experiences would seem to reinforce the potential for normality of birth and the value of both non-interventionist midwifery practice and inactivity as mechanisms of support. Not feeling in control There were many descriptions of times when others took over responsibility, leaving midwives feeling angry and frustrated: The midwives said they felt guilty when this happened and that they had let the woman down â€" again, they seemed to want to protect the woman from unpleasant experiences. However, they also seemed to lack conviction that women can birth without intervention given the right circumstances and support. Possibly, repeated negative experiences had reduced their confidence, and control by others eroded their authority. As NHS midwives, they worked in a large, bureaucratic organisation.

Chapter 7 : Midwives by Chris Bohjalian

Support "Midwives advocate for the protection of the rights of each woman, her infant(s), partner, family and community in relation to midwifery care." (NMBA) Once the woman has made her decision the midwife supports and advocates for her.

They employ a specific test called "Reading the mind in the eyes" test, assessing the ability to guess what the other person is feeling. These people are said to be extra empathic. I would bet that most midwives have this gene, as this ability is incredibly helpful in working with nonverbal women during labor and birth. Epub Nov In this study, we tested how a polymorphism rs of the oxytocin receptor relates to two key social processes related to oxytocin: Our results provide evidence of how a naturally occurring genetic variation of the oxytocin receptor relates to both empathy and stress profiles. Scientists in the United States have discovered that people who inherit a particular version of a gene called the oxytocin receptor score significantly better on an empathy test, while reacting less strongly to stressful stimuli. Bond Between Midwife and Client We all talk about bonding with our baby, but what about the bond which also happens between a pregnant woman and her midwife? After the birth of Harry and the 10 day checks I was really, really sorry to see my midwife leave my life. She had become a good friend to me and saw me through one of the most intimate phases of my life. I was lucky that the main midwife I saw during my pregnancy also insisted on staying with me for the birth of my son. Do women feel that they want the midwife to be part of that bonding circle, even though her time with the family is necessarily limited? Does this seem to increase the feelings of loss and abandonment when you no longer have those regular visits with her? Knowing that the relationship would eventually end I would prefer her to fade into the background, but not too much. After all we did spend 9 months together. We included our midwife and attendants in everything we did. When it came time to say good-bye I was sad and wished our relationship could continue. I still think about her and wish I could see her. In reality she can not possibly bond with everyone she attends. Nor would it be fair to her to expect her too. I try very hard not to insinuate myself inappropriately in that first hour or so after birth. I know some midwives who take advantage of this time to build "loyalty" in their clientele. They may not be conscious of it, but I know they make a point of being part of the "family circle" after the birth. Now, having said that, I really like most of my clients on a personal level, and yes, I miss them. I think of all my clients almost all the time. And, yes, this is one of the sweetest parts of being a midwife - feeling that connection to all those wonderful families in the community. Just today, I found myself driving behind a mini-van with a bumper sticker, "Support Your Local Midwife". I wanted to stop them to see whether it might be one of my clients. You feel proud that you did a good job of seeing them through this rite of passage, and you also know that a huge part of that job was getting them to a point where they feel enough confidence to move on to the next step.

Chapter 8 : We Stand Together Against Domestic and Family Violence - Australian College of Midwives

Women describe how the relationship with the midwives is important and how this gives rise to the development of trust, personalised care and empowerment. This has important ramifications for clinical practice and service development.

Chapter 9 : The Difference Between Midwife And Doula Explained â€“ Birth Takes a Village

I would bet that most midwives have this gene, as this ability is incredibly helpful in working with nonverbal women during labor and birth. Oxytocin receptor genetic variation relates to empathy and stress reactivity in humans.