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The relationship is everything: Women's reasons for choosing a privately practising midwife in Western Australia

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ABSTRACT

Objective: the purpose of this study was to describe women's reasons for choosing to birth with a privately practising midwife.
Design: a modified grounded theory methodology was used.
Participants and setting: the sample comprised 14 Western Australian women who had received maternity care from a privately practising midwife within the previous five years.
Findings: data analysis revealed three categories: the first was conceptualised as 'I knew what I wanted from my caregiver', which included sub-categories of: I wanted continuity of care; I wanted a relationship with my care provider; and I wanted a care provider with the same childbirth philosophy as me. The second encapsulated 'I knew what I wanted from my pregnancy and birth experience,' with two sub-categories, I wanted a natural, active, intervention free pregnancy and birth and I wanted my partner and family to be included. The final category was labelled 'I was willing to get the research to get what I wanted' and incorporated two sub-categories, I researched my care options and I researched my care provider options and the evidence around pregnancy and birth to be actively involved.
Key conclusions: findings offer insight around women's reasons for choosing this model of midwifery care and highlight that women know exactly what they want from their caregiver. Women valued working with their midwife towards a shared goal of an intervention-free, normal birth, researched their options and found mainstream services restrictive and focused on medical risk status rather than on the individual woman.
Implications for practice: findings will be of interest to maternity care practitioners and policy makers, as they highlight why some women prefer a social model of midwifery care that reflects a family centred, individualised and holistic approach. This insight can inform the development of maternity health care practices to recognise and accommodate the needs and values of all childbearing women.

Background

Childbirth is a life changing experience (Kitzinger, 2011) and regarded as more than a biological process. Traditionally, research relating to childbirth has focused on the physiological aspects; what has been less well reported is the impact of the birth experience on the woman's mental health, or the impact her experience has on her family's well-being. Pairman (2006) recognised the ripple effects of birth experiences to be far reaching, and warned that they cannot be underestimated as two seemingly identical birth outcomes can be experienced very differently.

Childbirth is often portrayed as a rite of passage into womanhood (Nelson, 2003; Davis-Floyd, 1992; Davis-Floyd 2003; Kitzinger, 2011) that influences the woman's sense of self and her place in society (Davis-Floyd, 2003; Kitzinger, 2011). A positive experience is likely to

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contribute to a sense of accomplishment and well-being that increases maternal confidence and, in turn, strengthens families and society (Hildingsson et al., 2013; Nilsson, 2013). Likewise, a negative experience is known to have a detrimental effect on psychological, social and physical health and well-being in the postnatal period and beyond (Goodman, et al., 2004; Waldenström et al., 2004; Thomson and Downe, 2008; Nilsson et al., 2010).

Pertinent to growing recognition of the association between childbirth experience and women's postpartum mental health, there now exists a growing body of work that focuses on women's perceptions of their maternity experience; examples include Bayes and colleagues' study of how women experience a scheduled caesarean birth (Bayes et al., 2008; Bayes et al., 2012), women's birth after a previous caesarean experiences (Godden et al., 2012; Kelly et al., 2013); home birth and birth centre-studies (Morison et al., 1998; Morison et al., 1999; Coyle et al., 2001a, 2001b), and women's experience of caseload midwifery and continuity of care (Williams et al., 2010).

There are a number of maternity care options for women to choose from. Caseload midwifery focuses on woman-centred care and encourages women to take control, make choices and contribute to care decisions (Johnson and Daviss, 2005; Freeman et al., 2006). Care in this model revolves around the woman and her family, is holistic, and focuses on women's individual needs. In caseload midwifery, the midwife is the primary caregiver and is responsible for the planning and provision of midwifery care for an agreed number of women (Andrews et al., 2006). As Pairman et al. (2010) describe, midwives working in this model partner with the woman so she can direct and control her own birthing experience and develop confidence as a new mother. Caseload midwifery is considered to be the gold standard of midwifery-led care (Warren, 2003; Andrews et al., 2006). Privately practising midwives (also known as independent midwives) offer caseload midwifery for a small number of women choosing either home or hospital birth.

We have evidence around women's experiences in specific care contexts such as complex care in maternity settings, Birth Centre and Midwifery Group Practice care (Fereday et al., 2009; Iida et al., 2012; McLachlan et al., 2012; Tracy et al., 2013; Sandall et al., 2013). Although there is some research around why women choose continuity of carer with a privately practising midwife, these studies have been concerned with the choice of home birth rather than the choice of a privately practising midwife as the primary care giver. There is no evidence on why women select caseload maternity care from a privately practicing midwife in Western Australia (WA). Private midwifery is seen as different because it is not a government funded option and most of the cost is covered by the women themselves. This study investigated what motivated WA women to choose this relatively costly option when free maternity care is readily available.

Methods

A modified grounded theory study within a naturalistic/constructivist paradigm was undertaken to explain the reasons for women choosing maternity care with a privately practising midwife working in a caseload model. The grounded theory approach is a comprehensive, integrated and highly structured, but also flexible, process (Glaser and Holton, 2004).

Prior to the commencement of the data collection, the researcher choose to identify her preconceived ideas and assumptions of why women would chose to have maternity care with a privately practicing midwife. As the researcher was now working as a privately practicing midwife, it was essential that she perform this exercise to reduce bias from her own lived experiences of providing private maternity care. Reflexive bracketing was used to facilitate the process of personal reflection by the researcher. Ahern (1999) describes reflexive bracketing as a process to make the researcher's personal values, background and cultural suppositions transparent. Ethical approval was gained from the university Human Research Ethics Committee (52/2011).

Women who had given birth with a Western Australian (WA) privately practising midwife as their main maternity care provider within the last five years formed the sample. The criteria of giving birth within the last five years was used, as recall of life events has been demonstrated as more reliable within this time frame (Moreton and Ward, 2010). A snowball technique was used to access participants. An email was sent to privately practising midwives with study information with a request to forward the information to women who may be interested in participating. Purposive sampling was then undertaken to provide rich information specific to women's experiences and reasons for selecting a privately practicing midwife (Teddie and Taqshakkan, 2009). Theoretical sampling was undertaken after it became clear during analysis of the interviews and development of the tentative categories that the majority of participants were multiparas and women seeking a vaginal birth after caesarean (VBAC). Therefore theoretical sampling was used to seek more primiparous women to see if the categories would hold for the decision making for these women, who did not have a previous pregnancy and birth.

Interviews are a 'conversation with a purpose' and as such a powerful data collection strategy, due to the one-to-one interaction between researcher and participant (Minichello et al., 1995). Open ended questions were employed such as 'What made you decide to seek care from a privately practising midwife'; 'what was it like receiving care from a privately practising midwife' and 'can you offer some examples of what you liked about the care?' Interviews lasted between 30 and 60 minutes; however, the researcher spent approximately two hours with participants, to establish rapport prior to the commencement of the interview. Although the interviewer was a privately practising midwife, no participants under her care were included. Recorded interviews were transcribed verbatim and then analysed using the coding, categorisation and memoing principles, underlying logic and procedures originally set down by Glaser and Strauss (1967) and expanded by Glaser (1978, 1992). Analysis of data was undertaken concurrently with data collection and when data saturation was achieved interviews were ceased. Data collection and analysis were completed between July 2010 and July 2013. Trustworthiness was assured through each member of the research team conducting independent analysis of interview transcripts and then meeting to negotiate categories and subcategories.

Findings

Fourteen women participated in this study, 11 whom were aged between 26 and 35 years; the remainder were 36–45 years of age. One woman had completed 12 years of compulsory schooling, 11 an undergraduate university degree and two completed postgraduate degrees. Three were experiencing their first pregnancy. One had an existing medical condition (i.e. essential hypertension). Half had previously given birth by caesarean section. Out of the 14 women interviewed, all had a vaginal birth with their most recent pregnancy. In this recent birth with their privately practising midwife, 12 women had a planned home birth, one had a planned hospital birth after labouring at home with her midwife, and one had an intrapartum transfer due to delayed progress resulting in an unplanned hospital birth. Demographic data is presented in Table 1.

Three categories emerged from analysis of the data that, together, portray participant women's reasons for choosing a privately practising midwife for their maternity care. The first was conceptualised as 'I knew what I wanted from my caregiver' and included the sub-