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Midwives' experiences of labour care in midwifery units. A qualitative interview study in a Norwegian setting

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ABSTRACT

Objective: In some economically developed countries, women's choice of birth care and birth place is encouraged. The aim of this study was to explore and describe the experiences of midwives who started working in alongside/free-standing midwifery units (AMU/FMU) and their experiences with labour care in this setting.
Methods: A qualitative explorative design using a phenomenographic approach was used. Semi-structured interviews were conducted with ten strategically sampled midwives working in midwifery units.
Results: The analysis revealed the following five categories of experiences noted by the midwives: mixed emotions and de-learning obstetric unit habits, revitalising midwifery philosophy, alertness and preparedness, presence and patience, and coping with time.
Conclusions: Starting to work in an AMU/FMU can be a distressing period for a midwife. First, it may require de-learning the medical approach to birth, and, second, it may entail a revitalisation (and re-learning) of birth care that promotes physiological birth. Midwifery, particularly in FMUs, requires an especially careful assessment of the labouring process, the ability to be foresighted, and capability in emergencies. The autonomy of midwives may be constrained also in AMUs/FMUs. However, working in these settings is also viewed as experiencing "the art of midwifery" and enables revitalisation of the midwifery philosophy.

Introduction

In economically developed countries, Norway included, hospital medicalised births are the norm [1,2]. Modern medicine and improved standards of living have saved countless lives during the birthing process, and giving birth in Nordic countries is regarded as safe [3]. However, considerable concerns regarding the various implications of medicalised birth have been highlighted [4–6]. The aim of the Norwegian government and health authorities is to maintain different birth settings and differentiated care [7,8]. Nevertheless, smaller units are disappearing and births are becoming both more centralised and medicalised over time [2].

Norwegian midwives are mainly trained and work in obstetric units. Practising midwifery in such units has been studied and has been described as a struggle between different paradigms and belief systems, namely, differences between biomedical/technocratic and physiological/normal/natural/holistic understandings of birth [4–6,9,10]. However, there is no mutual understanding or consensus among midwives regarding what normal birth actually is [9,11].

Midwives' experiences with midwifery care have been explored in other countries. These settings require midwives to be trained in the skills of normal birth [12–14]. Care in midwifery units is associated with promoting the midwife–mother relationship, facilitating a sense of higher satisfaction and autonomy for both mothers and midwives [13,15–19]. An American study noted that midwives' experiences of the birth centre atmosphere are described as relaxing, quiet, and less restricted with respect to time and guidelines [20]. A British report which explores hospital alongside midwifery units shows that philosophy and practice are closely interrelated and have significant value for midwives and that working in this kind of units enhances their autonomy [21]. Furthermore, it has been argued that midwives who choose to practice in birth centres are a special group of individuals who are seeking an accepting and positive culture and desire to work according to a woman-centred philosophy [19]. However, distressing factors are also reported from this type of work, such as the loss of obstetric

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skills, concern about burnout in a high-demand service, and lack of support from midwifery leaders [12,13]. How midwives experience the shift from the obstetric unit to midwifery unit in a Norwegian context is an unexplored field of research. To the best of our knowledge, no previous study has explored this aspect.

In order to enhance clarity, this paper will use the terminology freestanding midwifery unit (FMU) and hospital alongside midwifery unit (AMU), since birth centre may refer to both [21].

Methodology and methods

Aim

The aims of this study were to explore the experience of midwives who started to work in AMUs or FMUs and examine how they experienced labour care in this new setting.

Methodology

An exploratory design with a phenomenographic approach was chosen to explore and describe the variations in midwives' experiences of beginning to work in AMU/FMU [22]. Phenomenography was developed in Sweden in the 1970s by Marton and was derived from pedagogic research. It is described as an empirical study of the qualitatively different ways in which various phenomena in, and aspects of, the world around us are experienced, conceptualised, understood, perceived, and comprehended [22]. The main concern regarding credibility in a phenomenographic study is the relationship between the data and the descriptive categories [23].

Methods

In phenomenographic research, the preferred data collection method is semi-structured interviews with a few initial questions [23]. The interview questions were as follows: 1) Can you describe what it was like for you to start working in a midwifery unit? and 2) How would you describe working with labouring women in this setting? The questions were developed based on the aim of the study.

Research context

FMUs offer care during pregnancy for healthy women who expect normal births and want to give birth in an FMU. They also offer postnatal care and some of them provide counselling on women's health issues. The AMUs mainly offer labour – and postnatal care to healthy women and their babies. During birth women have access to non-pharmaceutical medication (and nitrous oxide) and one-to-one support by midwives and their birth supporter. Caesarean section is not available, and some midwives are trained in the procedure of performing a ventouse extraction. The guidelines for admittance and care are negotiated with the host obstetric unit. In FMUs, a general practitioner (GP) may be available if she/he is not occupied elsewhere. She/he can e.g. treat a sick infant or a mother with post-partum haemorrhage, but the GPs are generally not trained in obstetric care. In addition, training in midwifery units is not a required part of midwifery education in Norway. Births in all units are completely funded by the government. There is no official available record for the total number of births that occur in FMUs and AMUs, but less than 1% (5–600) of mothers gave birth in FMUs in 2012. Currently, there are approximately ten FMUs in Norway and presumably less than five AMUs. The actual number of AMUs is not available because there is no official record of these units.

Participants

We recruited ten participants who had worked in obstetric units prior to beginning their employment in AMU/FMU. They were recruited by phone calls to AMUs (n = 5) and FMUs (n = 5) with at least 100 births/year, and further in accordance with strategic sampling [24]. We presented our purpose for calling to the midwife (not necessarily a leader), answering the phone and asked if she could assist in approaching midwives working in the AMU/FMU. Hence, using snowball technique we phoned midwives as suggested by their colleague. All who were approached agreed to participate. The locations of the AMU/FMU were both rural and urban. The midwives were all very experienced, with at least ten years of training. All of them had worked in the AMU/FMU for at least six months, and some of them had worked there for more than ten years. Eight of the participants in this study had a choice about where to work, i.e., obstetric unit or AMU/FMU, because they were both conveniently located.

Data collection

Data collection occurred during 2010 in the midwives' homes, another private setting, a meeting room in an AMU/FMU or a university, based on the midwives' preferences. The interviewer (first author) is educated as a nurse-midwife (BSc) and sociologist (M.S.Sc), and she has 7 years of experience as a midwife in both obstetric units and FMU. The interviews lasted 60–150 minutes and were audio-recorded and transcribed verbatim. Anonymity was ensured by using pseudonyms.

Analysis

The analysis was inspired by Sjöström and Dahlgren [23] and Larsson and Holmström [25], as there is no single strategy for analysis in the field of phenomenography [26]. After the interviews, the analysis continued by listening to audiotapes and reading each transcription. This step aided in obtaining an impression of the data as a whole as well as each interview as a whole. In the second step, the interviews were read again, and text relevant to the interview questions was marked. In step three, the interview was searched for information regarding what it was like for the midwives to begin their practice in a new work setting and how they experienced working with labouring women in a midwifery unit setting. Excerpts were recorded regarding the predominant and non-dominant ways in which each midwife understood the phenomenon under study. Step four included categorisation of both predominant and non-dominant understandings within each category and this categorisation enhanced the representation of the various experiences. The categories refer to a collective level and demonstrate the variation in *possible* understandings of a phenomenon, i.e., this is not *the* understanding, as there can be other understandings. The categories do not apply to the understandings of any individual midwife, but they are a description of the variation of understandings between the midwives. Both authors read the transcripts, discussed the findings, and developed the categories.

Ethical comments

The study was reviewed and approved by The Data Protection Official for Research and was conducted in accord with the Nordic nurses' ethical research guidelines [27]. Midwives were approached and offered participation. Those who agreed to participate were provided full information and were asked for written consent.