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Norwegian nurse-midwives' perspectives on the provision of antenatal diabetes care in an outpatient setting: A qualitative study

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ABSTRACT

Background: There is limited research related to nurse-midwives' accounts of their provision of antenatal diabetes care in hospital outpatient settings. This study explored the perspectives and experiences of eight Norwegian nurse-midwives regarding the provision of the midwifery aspect of an antenatal consultation as part of the diabetes specialist team.
Methods: A qualitative descriptive study was used. Eight nurse-midwives aged between 37 and 58 years, representing four Norwegian hospital outpatient clinics, participated in individual interviews. Transcribed interviews were analysed in accordance with a qualitative thematic analysis.
Results: Three main themes were developed: "Approaching the women as persons in order to frame strengths and normalcy", "Managing different tasks judiciously" and "Balancing conflicting values". Some of the barriers were found to be related to the organisation of care, such as short timeframes with a medical focus, which overshadowed or forced the normalcy aspects of childbearing into the background. Managing risk and evidence-based knowledge were demanding tasks to fulfil in a judicious way. Some midwives experienced ambiguity while being forced to prioritise medical factors over woman-focused care while running others' errands, an act of balancing conflicting values.
Conclusions: The contextual conditions related to the organisation present barriers for pregnant women to receive woman-focused care beyond the medical approach. The midwifery contribution in this care setting should be clearly recognised and defined so that women can capitalise on the different professionals and their expert competencies and contributions in this setting.

1. Background

The maternity care service in Norway is organised on principles of level of risk. Women with diabetes, as a group, are regarded as being at higher risk of several complications, which applies to both the mother and the unborn baby.[1–3] According to the Medical Birth Registry of Norway (MBRN), in 2012 there were 61,368 registered births. In the same year, a type 1 diabetes (T1DM) diagnosis was registered in women for 4.9 out of 1000 births, 2.5 for type 2 diabetes (T2DM), and 23.6 for gestational diabetes (GDM), respectively.[4]

Women who are pregnant and who have diabetes are therefore referred to specialist antenatal care (S-ANC) in outpatient clinics to receive all or part of their antenatal care at the level appropriate to their diagnosis. They are subjected to frequent appointments with different health care providers and specialists where midwives have also become a part of the team. In this paper, we focus on the perspectives of nurse-midwives and their experiences of the provision of midwifery care as a part of the S-ANC team. Regardless of their level of antenatal care, all pregnant women should receive the normal course of ANC. According to Norwegian guidelines for antenatal care, the health care providers' mission in caring for pregnant women is twofold: on the one hand, working towards a person-centred approach to care; and on the other, focusing mainly on the early signs of complications in the pregnancy.[5] The person-centred approach to care takes the woman's perspective as the point of departure in the consultations, an approach that is congruent with Norwegian legislation stipulating that health care providers should work in partnership with patients.[6]

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Conversely, placing the focus on complications is representative of the biomedical and preventive element of the consultation. Thus, the guidelines place the health care professionals in a position of conflicting approaches to care from the outset of these consultations.

These (midwifery) consultations might be regarded as institutional conversations, not only because they take place in an institutional setting (hospital setting), but also because they differ from everyday conversation, or talk between friends. During the consultation the midwives will fulfil their professional contribution while also practising the inherent caring values in one way or another, but, being an institutional representative, they must also aim to solve pre-defined specific tasks and are expected to follow certain intuitional/organisational routines where distinct roles and obligations may be at play.[7,8]

According to Agar,[9] in institutional conversations, some conflicting perspectives may appear, as the participants may orient themselves and represent different perspectives in their interaction and communication with others. The pregnant women might be addressing issues from her everyday life world and situation, representing the client framework, while the voices of the midwives, alternatively, as institutional representatives, may resonate from the institutional framework, which refers to values and beliefs such as efficiency and directionality, congruent with the institution's predominant routines, principles, culture and work. Mishler[10] has found in his research regarding doctor–patient consultations that these frameworks might clash and "the voice of medicine" has the potential to overshadow "the voice of the life world."

Blaaka and Schauer Eri,[11] on other hand, refer to different health care belief systems when describing intrapartum midwifery which takes place at the *intersection* of the two health care belief systems. These two belief systems, the biomedical and the phenomenological, seem to fit well with the aforementioned concept proposed by Agar: the institutional framework represents the biomedical system, while the client's framework can be seen as the phenomenological system as it refers to the women's unique life situation and lived experiences.

In a review of research regarding midwives' perspectives on the provision of antenatal care, we found that most studies identified were conducted in the context of primary care settings, providing care for women in uncomplicated pregnancies. Few studies focus on the care providers' perceptions and experiences of practicing midwifery in S-ANC settings. In a Swedish study, Berg[12] found that the essence of midwifery care of hospitalised women with an obstetric risk, such as pregnancies complicated by type 1 diabetes, was defined as a balancing act between the medical and the natural perspectives on childbearing processes, by means of the transitional task of assisting women into motherhood.

Persson[13] found that midwives and obstetricians in Swedish primary health care settings perceived that their consultations with women affected by gestational diabetes were conflicting in nature. On the one hand, they were required to monitor the woman's pregnancy and to encourage lifestyle changes, but on the other, they were also expected to create an empowering relationship with the woman.[13] The obstetricians' perceptions pointed to conflicting, multifaceted interests: to address both the health and well-being of two individuals; the mother-to-be and her foetus.[14]

Carolan[15] found that diabetes nurse educators who provided antenatal care for women from disadvantaged backgrounds who had developed gestational diabetes during pregnancy acknowledged the extended need of these particular women to have the information individualised, which was challenging, given the setting. Being rushed and stressed with limited resources was a main barrier to making the information meaningful and to tailoring it to the individual needs of the woman. Midwives in this setting were also vulnerable to burnout.

The setting in which midwifery care takes place – the geography of caring – may play a significant role, as the location could either facilitate or limit a with-woman attitude. A UK study[16] found that women who received their first booking-appointment in antenatal consultation at home received better and more comprehensive information, choice and control when compared to women in hospital clinics.

These studies from different settings point to conflicting struggles; in emphasising the natural perspectives of childbearing, of being rushed and not being able to work according to the woman's framework, each of which seems to represent the values of the professional midwifery ethos. Student midwives in Ireland have reported similar findings; working solely on the premise of the institutional values was perceived to be stressful and contradictory.[17–19] Overall, there seems to be a challenge for midwives to synthesise, blend, and integrate both a person-centred "with-woman" and an "institutional" approach.

There is scant research on midwives' perspectives on the contribution of midwifery to antenatal care in the context of diabetes and especially in relation to a team organisation. The aim of this study was to explore and describe midwives' perspectives of their provision of the midwifery element of the antenatal consultation as a part of the specialist team organisation.

2. Methods

An explorative and descriptive design was used in the study. The epistemological position acknowledges that people communicate while they try to share their experiences with others. We gain knowledge through our communication and interactions when the context in which these interactions takes place is of significance. Human actions and meanings are regarded as being situated in social contexts[20] and, therefore, taking a contextual stance means that we consider the midwives' reality of practicing midwifery as being "real" for the persons who are having the experience. However, we also incorporate the role that context plays in the contribution and shaping of the participants' understandings and meanings of their experiences which form comprehension and subsequent understanding.

This research is part of a larger study on midwifery consultations in antenatal diabetes care in Norwegian S-ANC clinics.[21–23] Five hospital clinics were initially approached; of these, four agreed to participate in the study. The head midwife at each setting provided contact with midwives at the S-ANC who then were given written and oral information about the study by the first author. Eight midwives from four outpatient clinics in different areas of Norway agreed to participate. Five of the participating midwives provided S-ANC on a weekly basis. All participants were nurses a priori and obtained their midwifery degrees post-nursing studies. Two participants were also diabetes specialists. The midwives' ages varied between 37 and 58 years, with a mean age of 51.

The pregnant women scheduled for antenatal check-ups met the diabetes team, consisting of a midwife, an endocrinologist and an obstetrician, on a particular weekday at the clinic. In all clinics, the women followed the same sequential order: the women first met the midwife and then went to either the endocrinologist or the gynaecologist. The allocated time for the midwife visit/check-up in three of the clinics was stipulated to be 20 min. In the fourth clinic, 15 min was allocated. The allocated period for the doctors' visits varied between 12 and 15 min.

The data were collected by interview by the first author (CFR) and these were audio taped with a digital voice recorder. Two questions were posed: (i) What do you, as a midwife, consider being of significance in the encounter?; and (ii) Do you have some