Sexual & Reproductive Healthcare 16 (2018) 132–137

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

Midwifery care based on a precautionary approach Promoting normal births in maternity wards: The thoughts and experiences of midwives

Ingvild Aune[a,*], Oda Villemo Holsether[b], Anne Marte Tinholt Kristensen[c]

[a] Midwifery Education, Faculty of Medicine and Health Sciences, Department of Public Health and Nursing, NTNU – Norwegian University of Science and Technology, Mauritz Hansens gt. 2, 7004 Trondheim, Norway
[b] Molde Hospital, Parkveien 84, 6407 Molde, Norway
[c] Kristiansund Hospital, Herman Døhlens vei 1, 6508 Kristiansund, Norway

ARTICLE INFO

Keywords:
Normal birth
Midwives' experiences
Individual care
Ideology

ABSTRACT

Objective: The aim of this study was to gain a deeper understanding of the thoughts and experiences of midwives in the attempt to promote normal births in Norwegian maternity wards.
Methods: A qualitative approach was selected for data collection, and the data presented are derived from in-depth interviews. Nine midwives at three different maternity wards in Norway participated in the study. The qualitative data were analysed with the help of systematic text condensation.
Results: The findings included two main themes: (1) "Individualized maternity care" (2) "A woman-centred and a biomedical perspective - a dilemma. Working in a small maternity ward increased the possibility for continuous support during labour and continuity of care throughout pregnancy, birth and the postnatal period. The midwives had a great desire to promote normal births with a minimum of interventions. Still, they adhered to an ideology based on both a woman-centred and a biomedical view of birth. Their work was often based on a precautionary approach in which problem-solving strategies were related to potential risks.
Conclusion: The midwives experienced challenges, as they worked in an environment where different ideologies prevailed. They utilized the positive aspects of small maternity wards, like the opportunity for continuous support during labour and continuity of care during the childbearing process. Midwives should encourage discussions about their precautionary approach and the use of technology for low-risk women, while reflecting on their own views on normal births.

Introduction

In Norway and other Western countries, maternity care has over the last decade focused on risk factors for the mother and child. This is associated with an increasing use of scheduled inductions, augmentation of labour and caesarean sections [1–3]. In Norway, maternity care is organised at two bureaucratic levels; antenatal care is part of the primary health services, which are organised at the municipal level, while the special health services are responsible for intrapartum and postnatal care. Some midwives have combined positions in the primary and special health services. The care is differentiated and the differentiation is intended to adapt monitoring and follow-up of the woman during birth to a specific risk assessment. In the special health services, maternity care is organised at three different levels that vary according to the expertise available; small midwifery-led units, maternity wards and birth clinics [4]. Birth clinics have the highest level of competency and emergency preparedness. The maternity wards are obstetric-led units, but women who give birth at maternity wards are generally considered to be in the low-risk category. The midwife-led units are only available for healthy women with a known medical record [5]. Midwives have the responsibility and expertise for normal births, while obstetricians are in charge when the birth is considered high-risk. This requires close collaboration between these two professional groups [6].

According to the International Confederation of Midwives' guidelines [7], pregnancy and childbirth are normal physiological events, which involve both sociocultural and emotional aspects. Maternity care should be individualized and adapted to the woman's cultural and social needs while being safe for the mother and baby. ICM [7] defines a normal birth as a unique, dynamic process based on physiological and psychological interaction between the mother and the fetus. A normal

* Corresponding author.
E-mail address: ingvild.aune@ntnu.no (I. Aune).

https://doi.org/10.1016/j.srhc.2018.03.005
Received 30 August 2017; Received in revised form 18 February 2018; Accepted 22 March 2018

birth takes place when the woman commences, continues and completes labour with the infant being born spontaneously at term in the vertex position, without any surgical, medical or pharmaceutical intervention. The promotion of a normal childbirth is included in the ICM Scope of Practice [8], and midwives should have the competence to support the physiology of childbirth. However, midwives and obstetricians may understand the birth process in qualitatively different ways, and the birth paradigm often consists of two opposite positions. Walsh [9] describes these as the biomedical model and the woman-centred model, where the former is reductionist and emphasizes pathology, safety and technology. The woman-centred model is described as a holistic approach, where physiological, psychological and the spiritual aspects are integrated. The woman-centred model focuses on normalization and the ability to realize one's potential, with technology as a secondary factor.

According to The World Health Organization's principles of perinatal care in Europe, normal births should be de-medicalized, which would imply a change in maternity care that ensures that unnecessary interventions are not used [10,11]. There should be a valid reason for interfering with the natural process of childbirth. In spite of this, the advance of medical technology has been accompanied by a rising number of interventions [12]. Unnecessary medical interventions during labour and birth may compromise the safety and emotional well-being of both the mother and baby [2]. A normal birth is associated with a number of benefits for the mother and the newborn baby [13–16], and may be a necessary condition for a positive birth experience [17]. A normal birth enhances the woman's psychological, postnatal well-being [18] as well as confidence and self-esteem in her role as a new mother [19]. Renfrew et al. [20] stress that this change in maternity care includes supportive care, which works to strengthen the woman's capabilities, while being tailored to her needs. Care should focus on promotion of normal reproductive processes, and first-line treatment provided when necessary. Based on the best available evidence in 2014, six care practices that support the normal physiologic process of labour and birth have been identified: Letting labour begin by itself, freedom of movement during labour, providing support during labour, no routine interventions, spontaneous pushing in non-supine positions, and ensuring that the mother and baby remain together [21–26].

Studies show that low-risk women are less likely to have a normal birth in an obstetric-led unit than in a midwife-led unit [27–32]. Midwives at obstetric units experience challenges related to promotion of normal births due to the department's active management principles that focus on the progress of birth [33]. There is little research in Norway on midwives' experiences of working with low-risk women in obstetric-led maternity units. The objective of this study was to provide a deeper insight into the midwives' thoughts and experiences regarding the promotion of normal births in maternity wards in Norway.

Methods

Data collection

A qualitative approach was selected for data collection, and the data presented are based on in-depth interviews. This type of interviews are suitable for reflections on a specific topic [34], and in this case enables us to gain knowledge and a deeper understanding of the thoughts and experiences of the midwives related to promoting normal births.

Participants

An email with information about the study and a request for participation was sent to the unit leader at three maternity wards in different areas in Norway, with information about the study and a request for participation in it. These maternity wards have about 500 births a year. The unit leader forwarded the request to the midwives via email and at a unit meeting. To ensure a representative sample, both newly educated and experienced midwives were invited to participate. The inclusion criteria were that the midwife either had from one to five years of professional experience or more than ten years of professional experience. A total number of nine midwives from three different maternity wards (three from each hospital) volunteered to participate in the study. They were given written and oral information about the aim of the study and a guarantee of confidentiality. Subsequently, they signed a written form of consent. Although the majority of the midwives had only professional experience from maternity wards, some also had work experience from birth clinics. All midwives had worked at the ward for at least one year and some had combined positions in both antenatal and intrapartum care. The informants consisted of four midwives with less than five years of work experience and five midwives with more than 10 years of professional experience. The age of the informants ranged from 29 to 58 years. Eight of the interviews were conducted at the maternity ward where the midwives worked and one took place at the midwife's home. There was no prior personal relationship between the researchers responsible for the interviews and the midwives. Each interview lasted 30–60 min. An interview guide with open-ended questions was prepared in advance (Table 1). The questions were derived from a literature review on the topic and based on professional knowledge and experience. The guide was revised following a pilot interview. The guide was used to limit the conversation to one relevant subject rather than a number of specific questions [34]. Follow-up questions were asked where it was required to clarify opinions and statements. After nine interviews, data saturation was achieved. The data assembled were rich in content, as all the midwives spoke freely about the topics and offered detailed accounts of their experiences and reflections. This made it possible to discern the knowledge and attitudes underlying their work.

Data analysis

The interviews were tape-recorded and transcribed verbatim. The transcribed interviews were analysed by the authors with the help of systematic text condensation. This method is developed by Malterud [35], and is a modified version of Giorgi's [36] phenomenological analysis. The purpose of the phenomenological descriptive approach is to generate knowledge about the informants' experiences in a particular area. The researchers try to identify the essence or themes that emerge from the data. The method of analysis followed a four-step analytical procedure [34]. The first step involved gaining an overall impression, and all interviews were carefully read. The broad picture was considered more important than the details, and the researchers looked for themes that reflected the thoughts and experiences on how to promote a normal birth in the maternity ward. An effort was made to bracket hypotheses, preconceptions and the theoretical framework of reference. In the second step of the analysis, text units that might shed light on the experiences of the midwives were sorted. The material was systematically reviewed sentence by sentence to identify meaningful units. These units were coded by identifying and classifying all the meaningful units in the text that were related to the themes identified in the first step of the analysis. In the third step, the contents of each of the coded groups were condensed, abstracted and summarized. The last step of the analysis consisted of re-contextualization. The reflections,

Table 1
Interview guide.

What thoughts do you have when following up a healthy pregnant woman giving birth at the maternity ward?
Can you tell how you work with healthy pregnant women during their childbirth?
What experiences do you have with intrapartum care at this maternity ward when trying to promote a normal birth for healthy pregnant women?
Describe possible challenges at this maternity ward related to the promotion of a normal birth.