The outcomes of midwifery practice have been examined in a series of studies over the past several decades. They have demonstrated that midwives provide safe care, achieve positive outcomes in women’s and infant’s health, and often use fewer interventions compared with their physician counterparts. Kennedy has conducted several prior research studies to distinguish specific processes, outcomes, and experiences of midwifery care. Although results of these studies were illuminating, further exploration was necessary to place these findings into the context of actual midwifery practice. This article presents the third stage in Kennedy’s research program to develop theoretical linkages between the processes of midwifery care and outcomes for women and their families.

BACKGROUND

Outcomes of midwifery care in the United States, as measured by maternal and infant morbidity and mortality, have been carefully scrutinized and are consistently excellent in both low and moderate risk populations. The Report of the Pew Health Professions/UCSF Center for Health Professions Commission on the future of the profession notes that midwifery’s many strengths and contributions have not been fully used to meet today’s health care needs and that further description and outcome analyses of midwifery methods and processes are essential.

The study by Thompson et al. stands as seminal in the early development of midwifery theory identifying critical indicators of care. Cragin critically examined the early theoretical efforts of Lehrman, Thompson and her associates, Morten and her colleagues, and Kennedy. She notes there is “remarkable consistency in the identification of concepts important to the discipline, which are much broader than those derived from a medically based philosophy.” However, she emphasizes the importance of future study to refine and clarify these concepts and their contribution to midwifery knowledge and women’s and family health.

Kennedy conducted two prior exploratory studies to understand the complexities of midwifery practice. The first used phenomenology, a qualitative method that moves toward understanding a person’s experience of a particular phenomenon (e.g., chronic illness, pain, or birth). In this study, she examined women’s experience with midwifery care. The women identified the essence of the experience as one in which a relationship was built on respect, trust, and alliance. Ultimately, it was this respect that empowered the women to determine and direct their care.

Kennedy’s second study used the Delphi method to gain consensus about the essential elements of midwifery practice. This method queries a panel of experts chosen specifically for their knowledge about the issue being studied. Midwives across the country were nominated as representative of exemplary practice and adherence to a midwifery philosophy. A second panel was formed of women who had been recipients of care by those midwives. The study revealed three dimensions of practice, including therapeutics, caring, and professional. Although these results moved the state of the science forward, the results came from an academic exercise and not the context of actual practice. It was essential to build on these early exploratory studies to clarify the findings and to develop a framework that could be empirically tested in clinical practice.
METHODS

The research questions were 1) what processes of care and beliefs emerge as central in midwifery practice when described in actual clinical scenarios and 2) are there linkages between midwifery processes of care and short- and long-term outcomes for the woman and her family? Narrative analysis was chosen for this stage of research to best explore the context of practice. Koch describes the use of narratives or stories as a valuable research method because it creates paths to solve clinical problems, provides a voice to clients and nurses, informs social policy, and addresses diversity through understanding. “Narrative forms reveal individual’s construction of past and future life events at given moments in time.”

Stories help the often invisible parts of our work to be seen. Narratives provide us with the opportunity to hear specific ideas, unique approaches, and thoughts about how best to provide care in the context of actual clinical scenarios.

A purposive sample of 14 midwives and 4 recipients of midwifery care were recruited to provide scenarios that described their midwifery practice or care experience. In Kennedy’s prior Delphi study, panelists were asked to list specific qualities and traits, processes of care, and outcomes they believed to be most important in the practice of midwifery. Many wrote vignettes as they made their list, using stories to illustrate their point. Because the current study used narrative method, we chose to recruit these storytellers. In qualitative research, this is similar to theoretical sampling in which participants are recruited specifically because of prior research findings to learn more about specific questions. Three of the midwives were not in the original Delphi study but were theoretically sampled based on emerging findings. Sampling continued until no new information was emerging. This is called theoretical saturation and reflects the point at which data collection may cease. This occurred quickly with the recipients of care because their narratives were highly resonant with interview data obtained from women who participated in Kennedy’s prior study on women’s experience with midwifery care.

The 14 midwives were an experienced group of clinicians averaging 20 years of practice (range = 6–40). Most (n = 13) were certified by the American College of Nurse-Midwives (ACNM) mechanisms; one was dual-certified through ACNM and the North American Midwives Registry, and one was not nationally certified. All were licensed to practice. They had practiced in a variety of settings throughout their careers, including hospitals, birth centers, and homes. Twelve were Caucasian, one was Latina, and one was African American, generally reflecting the demographic characteristics of U.S. nurse-midwives. The recipients of midwifery care also reflected the three birth settings and one had received only gynecologic care from her midwife. All were Caucasian, which is not reflective of the general population cared for by midwives in the United States. All participants for both groups were women.

The University of Rhode Island Institutional Review Board approved the study. Each participant was asked to tell one or more stories that most reflected her midwifery practice (midwives) or care experience (recipients of care). Interviews, lasting 60 to 90 minutes, were conducted by using videotape to collect the data. Informed consent was obtained from each participant before data collection with specific permission about future use of video clips in educational and professional presentations. The videotapes were transcribed, checked for accuracy, and entered into Atlas.ti software for analysis. The techniques of Geanellos in story analysis were used to guide the interpretation of the data. The steps are outlined in Table 1 and include a presentation of the story, interpretation of its meaning, connecting it to what is currently known about practice, and identification of new knowledge.

When qualitative research methods are used, the researchers become the instrument of analysis; therefore, it is essential they are prepared and bring perspectives that will inform the process. The research team was comprised of three expert midwives, including one from Thailand and two graduate midwifery students. The primary investigator was experienced in qualitative research, and two of the midwives were completing doctoral research residencies in qualitative analysis. Together, this team brought multiple perspectives, adding to the rigor during data checking, coding clarification, and interpretation.

Atlas.ti was used to assist in data management, organization of coding, tabulation of coded text, and identification of conceptual relationships within the qualitative data. An initial coding structure was created with the members of the research team using two of the narratives. The rest of the narratives were then coded, and their findings were examined for interpretive consensus in face-to-face discussions.
Table 1. Steps in Narrative Analysis

<table>
<thead>
<tr>
<th>Steps</th>
<th>Analytic Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storied experiencen</td>
<td>Presenting the storied experience of the midwives and recipients of midwifery care through the use of videotaped interviews</td>
</tr>
<tr>
<td>Reflection</td>
<td>Focusing on story details, deliberating, speculating, contemplating, exploring, interpreting, and discussing</td>
</tr>
<tr>
<td>Coding of text using constant comparative techniques and detailed memos</td>
<td></td>
</tr>
<tr>
<td>Attending to thoughts, feelings, assumptions, and understandings</td>
<td></td>
</tr>
<tr>
<td>Drawing meaning and relationships</td>
<td></td>
</tr>
<tr>
<td>Progression</td>
<td>Gaining insight about practice and beliefs, linking and integrating new knowledge with old identification of future directions for practice and research</td>
</tr>
</tbody>
</table>

Adapted from Geanellos.18

At the conclusion of the coding phase, the categories were compared with the prior study findings for resonance and dissonance.

The final phase of analysis was to thematically align the codes as they related to one another. This interpretative process was completed independently by two of the researchers. As the categories were aligned, the researchers conceptually clustered them into three main themes. Considerable time was spent on this step to understand the fundamental meaning and structure of each of the themes and how they were situated in the framework. Naming them became the greatest challenge and was discussed at length with additional researchers experienced in qualitative methods.

FINDINGS

When the results of the narrative analysis were compared with the Delphi findings, there was an overall congruence of 80% across all codes. All of the themes identified in the phenomenology study appeared in the narratives. A more complete description of the analytic comparison of the studies is reported elsewhere.19 The congruence of the narrative analysis with the results of the prior studies is important because of the consistency of findings. However, the stories provided greater depth and description of foundational issues in practice, specifics about how the midwife enacted care, and some new findings that had not been seen in prior studies. Nineteen types of scenarios were relayed by midwives and five by the recipients during the narrative interviews and are listed in Table 2. Three overarching themes were identified: 1) the midwife in relationship with the woman; 2) orchestration of an environment of care; and 3) life journeys, or outcomes, for the woman and the midwife. Table 3 provides a listing of the codes clustered thematically with the number of text passages assigned to them. The danger of presenting such a linear schema is that it does not fully represent the dynamic nature of practice. This is not our intent; rather, it is to simply portray how the data were conceptualized and organized.

The Midwife in Relationship with the Woman

The first theme describes the structure of the relationship of the midwife and the woman. Mutuality emerged as foundational for the midwife’s relationship with the woman. This concept suggests that the midwives regard themselves on an equal level with the woman, recognizing that women bring a knowledge base to the clinical situation as important as the midwife’s. It requires being open to the woman and what she brings to the relationship, and at times, entails personal disclosure. The latter was a new finding and noted in five of the scenarios.

That the ability to be close to someone is so available and so ripe if you’re only willing to take the moment and to share yourself, as much as we ask them to share with us. . . .

Respecting and responding to the woman’s desires indicates the midwife regards the woman’s goals even when they may differ from her personal values.

I had a hard time letting go of the fact that people don’t necessarily feel like giving birth as something that should be a challenge. They say ‘I want an epidural, why would anyone want to go through pain?’ . . . So, I’ve had to give up some of that
Table 3. Thematic Representation of Narrative Coding Scheme

<table>
<thead>
<tr>
<th>Processes of Care</th>
<th>Orchestration of an Environment of Care</th>
<th>Outcomes of Care</th>
<th>The Life Journeys of the Midwife and the Woman</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Midwife in Relationship With the Woman</strong></td>
<td><strong>Founded on:</strong></td>
<td><strong>Enacted by:</strong></td>
<td><strong>Outcome for the Woman:</strong></td>
</tr>
<tr>
<td>• Mutuality (30)</td>
<td>• Advocacy (23)</td>
<td>• Response to women’s desire (30)/meeting the woman where she is (23)</td>
<td>• Family-centeredness (50)</td>
</tr>
<tr>
<td><strong>Enacted by:</strong></td>
<td>• Role model (9)</td>
<td>• Validation (29)</td>
<td>• Power (17)/“she did it” (10)</td>
</tr>
<tr>
<td>• Response to women’s desire (30)/meeting the woman where she is (23)</td>
<td>• Conduit (7)</td>
<td>• Participatory care (25)</td>
<td>• Trust (14)</td>
</tr>
<tr>
<td>• Validation (29)</td>
<td>• Accountability (5)</td>
<td>• Continuity (22)</td>
<td>• Safety (14)/feeling safe (5)</td>
</tr>
<tr>
<td>• Participatory care (25)</td>
<td><strong>Supported by:</strong></td>
<td>• Respect (22)</td>
<td>• Protection (11)</td>
</tr>
<tr>
<td>• Continuity (22)</td>
<td>Qualities and Traits of the Midwife:</td>
<td>• Intimacy (7)</td>
<td>• Transformation (11)</td>
</tr>
<tr>
<td>• Respect (22)</td>
<td>• Humility/ego (16)</td>
<td>• Disclosure (5)</td>
<td>• Community services (8)</td>
</tr>
<tr>
<td>• Intimacy (7)</td>
<td>• Integrity (14)</td>
<td><strong>Supported by:</strong></td>
<td>• Life-long memories (7)</td>
</tr>
<tr>
<td>• Disclosure (5)</td>
<td>• Realist (11)</td>
<td>Clinical expertise and skills (46)</td>
<td>• Healing (6)</td>
</tr>
<tr>
<td><strong>The Midwife’s Care of Self:</strong></td>
<td>• Non-judgmental (7)</td>
<td>• Knowledge of self and limits (16)</td>
<td>• Felt cared for (5)</td>
</tr>
<tr>
<td>• Midwife relationships (7)</td>
<td>• Passion for midwifery (7)</td>
<td>• Cultural awareness (12)</td>
<td>• Satisfaction with care (3)</td>
</tr>
<tr>
<td>• Personal care of self (6)</td>
<td>• Humor (6)</td>
<td>• Intuition (15)</td>
<td><strong>Outcome for the Midwife:</strong></td>
</tr>
<tr>
<td><strong>Founded on:</strong></td>
<td>• Personal reactions (31)</td>
<td>• Cultural awareness (12)</td>
<td>• Defining midwifery (29)</td>
</tr>
<tr>
<td>• Disclosure (5)</td>
<td>• Follow-up (22)</td>
<td>• Constant inquiry (10)</td>
<td>• Growth as a midwife/clinical wisdom (15/continuing to learn (18)/changing practice style (6))</td>
</tr>
<tr>
<td><strong>Enacted by:</strong></td>
<td><strong>Founded on:</strong></td>
<td>• Calm (6)</td>
<td>• Conflict resolution (14/changing the system (11))</td>
</tr>
<tr>
<td>• Disclosure (5)</td>
<td>• Support of normalcy (97)</td>
<td>• Assertive (5)</td>
<td>• Professional teaching (11)</td>
</tr>
<tr>
<td>• Disclosure (5)</td>
<td>• Trust in women (23) and belief in their strength (42)</td>
<td>• Hand skills (4)</td>
<td>• Frustrations in practice (10)</td>
</tr>
<tr>
<td><strong>Supported by:</strong></td>
<td><strong>Enacted by:</strong></td>
<td>• Vigilance (3)</td>
<td>• Honor (9)/pride (4)</td>
</tr>
<tr>
<td>qualification knowledge, skills, or personal qualities and traits of the midwife.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

( ) Indicates number passages coded from the transcripts. Founded on indicates a philosophical belief or stance. Enacted by indicates processes used. Supported by indicates specific knowledge, skills, or personal qualities and traits of the midwife.

thinking—you know, [that] this is the right way; you should want to feel that pain and feel proud of yourself after you give birth. . . . Being able to support people in their choices, though they might not have been my choices.

The midwives individualized their care, identified in our coding scheme as “meeting the woman where she is.” The actions in doing this were purposeful and geared toward knowing her as a unique person. One of the recipients of care noted how her midwife does this during her annual visits; “She sits down, she asks you questions about the past year. . . . things that are really related to your passion, what you are doing.” One of the midwives was very specific in how she personally meets the woman.

. . . my very first step is to always connect with her. That may mean squatting down where she is; it may mean pulling a chair up that puts me at eye level with her; it may be standing next to her if she’s up and walking so that we have eye contact. That to me is where it begins. That somehow she sees me; she can see my eyes and my face. . . . to connect with her as she is. . . .

The midwives used validation to acknowledge the woman’s feelings and concerns. It was a realistic and honest reflection “with” the woman about the current situation. One midwife described a woman in second stage with five centimeters of caput showing who suddenly said, “I can’t do this.” The midwife said her style had changed over the years in handling that situation and rather than having her push through that sense of panic at the end, she now stops and asks her why, as long as there is no physiologic reason to facilitate the birth. In this situation, the woman spent the next 45 minutes talking with the midwife and her husband about her fears of being a mother and whether she needed medication for this last stage. As soon as she decided to have some medication, she began to push and went on to deliver without it, by her choice. She later expressed delight with her birth and her baby. When asked to reflect on her
change in practice, the midwife said that she had learned how validating a woman’s fears often facilitated her ability to handle them.

...when people said, ‘I can’t do it,’ instead of saying, ‘Yes you can,’ and sort of being confrontational with them, which I think initially I thought was an empowering thing to do . . . . I found [myself] saying, ‘OK’—just accepting that . . . not trying to talk them out of what they are feeling about something, but just validating that their feelings are valid . . . they usually come around to grappling with it and moving ahead . . . .

We heard many stories that depicted the variety of relationships between the midwife and the woman. Although it always appeared to be professional, a personal connection, partnership, and often friendship were apparent. One of the recipients of care talked about the loss she felt in leaving the relationship at the end of the pregnancy, where she had felt so accepted and so special.

I tell you, I wasn’t ready to do that. It was almost like this nervous feeling that I wouldn’t see her . . . I’ve seen her every month and then every week. I looked forward to every visit . . . She knew me, she knew my family, she knew my profession; it was wonderful. It was like going to visit a friend every single time . . . Feeling the baby and hearing the heartbeat and her excitement was like it was her first delivery too . . . .

Kennedy’s prior research had identified a number of these concepts, but the stories told in this study provided evidence specifically for how these were enacted in clinical practice. The building of the relationship between the midwife and the woman provided the foundation for the midwife to orchestrate an environment of care to meet the woman’s needs and is described in the next theme.

Orchestration of an Environment of Care

Orchestration was chosen to describe the midwife’s “art” in creating an environment in which the woman’s desires were met, where she was kept safe along the way, and where normalcy was preserved. It included an awareness of the women’s context and care setting and creating space where the woman’s physical and emotional needs could be met. Of the three themes, it is the most complex and suggests that the midwife maneuvers the health care system as an advocate for the woman. Preservation of “normalcy” during pregnancy and birth was predominant, highly challenging, and is discussed more fully in a separate article devoted solely to this concept.20

Two important foundational concepts were advocacy and acting as a “conduit.” Advocacy was complex and included supporting what the woman wants to have happen, aligned with what the midwife believes is safe to happen. This may be to keep interventions at bay, to cope with difficult family members, or to convince nursing staff that all is safe. Some advocacy changes policy and some occurs in closed-door sessions with consulting physicians. At times it included helping women come to grips with difficult life issues. One midwife talked how she sometimes advocated for a woman to take charge of her life, even during labor. She described attending a birth years ago when the woman’s labor began to stall,

I asked if she had any idea what was standing between her and having this baby. First she looked bewildered, . . . then she said, ‘Well, I can tell you that my mother wants to come right after the baby is born and I really don’t want her. I really don’t want her until later . . . .’ I said, ‘here’s a dime, go call your mother.’ She marched right down there, called her mother, told her she didn’t want her to come until the baby was a week old, came back, got into bed and had the baby—just about like that. Of course the activity helped, too!

One of the most intriguing foundational concepts for orchestrating care was that of working as a conduit and portrays the often invisible work of midwives. Seven of the midwives described a process where they believed they served as a channel for the woman’s process. The word conduit was actually used by several and sent us to the dictionary to fully understand what they were trying to say. Conduit is derived from Latin for “conducere,” which means to conduct, often referring to the conveyance of water.21 When visualizing a conduit, water is flowing, but the channel conducting the water is not seen. The story in which the concept first appeared was that of a young primigravida immigrant woman. She was extremely timid and had probably been sheltered away much of her life. The midwives debated her level of risk for a birth center, but this midwife advocated for her admission to the caseload. Her labor was long and the midwife assessed that although she had an unusual pelvis, she had adequate room for birth; it would just take patience and positioning. She stayed with her throughout the labor helping her to rock, take showers, providing comfort; all the while the woman made no eye contact in her shyness. As she progressed toward full dilation, she was encouraged to just follow her body—no pressure, to just push as she felt the need. The midwife described a transformation in this young woman at the birth.

This woman, who I had never made eye contact with . . . I had never seen her smile, say a thing herself . . . all of a sudden she looked up . . . she smiled . . . she reached out, she received her baby and [en]folded it. I said to myself, here this girl was; has been kept away, and now all of sudden here she is. Done this wonderful thing . . . she was accomplished.
The midwife described her own role at this birth in the following way. “Why I could have just faded into the woodwork because it was all her [midwife’s emphasis]. I realized that I’m just a conduit.”

These foundational concepts imply that the midwife works to meet the woman’s needs and that the woman has an experience where she is the one receiving credit for the hard work she has done. It entails a power differential that shifts control from the provider to the woman.

Another aspect of orchestrating an environment of care is exemplified in the management process, which was highly evident and underscores the majority of the clinical scenarios. This did not mean they “managed” the birth, but rather they carefully monitored unfolding events. Critical to the assessment process was their ability to have a contextual awareness of the woman and the setting in which care takes place. This helped them create physical and emotional space for the woman that feels safe and supports her needs. The midwives believed best care was provided when the whole woman was understood in her context—specifically, what it was that she brought to the labor, birth, or health care experience.

...I think [you] always have to have a good ear as far as listening to people. But I think taking it a step further; listening and then trying to out what to do with all these issues that some of these people have faced in their lifetime that I have no experience with...listening and being able to help a woman find her strength and use her strength.

Balanced with understanding the woman’s context was an awareness of the setting and environment in which midwifery care was taking place. These included professional relationships, philosophies, system policies, and those people involved with the woman. One midwife described how she negotiates the physical environment by dimming lights and “getting the heavy medical stuff out of sight” and then assesses the social environment of those who are attending the woman. She uses that knowledge to create a space that serves the energy and flow in the room.

Over time I had to learn or become more aware of the social environment. Where was the strong, confident energy coming from in the room? Where was the black hole of fear? Where are the hope and excitement and encouragement? I began to feel that those things could be translated into real awareness...To be able to walk into a room and know what is serving and what is not...That’s a feeling, I don’t have a lot of science about that. It’s a feeling. I come in, I read the tempo, the dance of the labor and who’s in sync and who’s out of step. Then just very subtly, and in a low key way redirect it, or replace it; and hopefully bring it to place where the mom is getting what she needs.

Much of the orchestration we saw in the stories is probably not seen by the women it served. We heard many battles as midwives fought to change hospital policies and restrictive protocols, go out on limbs to create a plan of care that met a woman’s unusual needs, and to build communities and safe places for women. As a process, orchestration appeared to be directly linked with outcomes and are described in the following theme.

Life Journeys for the Woman and the Midwife

We chose to call the third major theme “life journeys” to reflect the effects of midwifery care as short- and long-term outcomes for the woman and the midwife. We selected this term because the narratives often portrayed effects beyond the common indicators used in women’s health care. We were struck by the depth of the sense of accomplishment and emotion that went with the stories. The midwives described transformative experiences in which women achieved victories and strength. They also described their own growth, learning, and at times humility. This theme drew on the earlier foundational concepts, including a trust in the woman’s strength and a belief that she would make the right decisions for herself. It required accountability to reflect, to continue to learn, to change when needed, and to revolutionize systems to improve care for women. There was a clear sense of outcome and journey for the midwife. This had not been seen in the prior studies and represents a new finding. We have chosen several stories to portray these life journeys.

A sense of achievement and healing was described by one of the recipients of midwifery care as she told about her births.

I also had a lot of doubt about myself and my capability of having a natural birth and all of that...I very much felt like a failure after that first birth [in a hospital]. So I went into it not sure that I could do it at all...I just kept putting one foot in front of the other, and I think that she [the midwife] sort of sensed that because at one point at the very end she said, ‘I think you’re holding back or something.’ Then I told her I was just very afraid that I couldn’t do a natural birth, and I would be at home with no way to change that situation. I just wasn’t sure I could do it. She reassured me that I could...[She went on to give birth at home]... But that was a really healing thing for me because he [the baby] was able to go right to my stomach. He was able to nurse immediately and he didn’t cry.

One midwife described her care of a woman and her family over many births (including grandchildren) throughout her career. Both the woman and the midwife grew and learned from one another.

When given the opportunity at every moment, she engaged sharing...it affirmed to her that someone
was listening and that whatever she had to say was incredibly important to her. That had not been her previous experience in her births prior to the fourth baby. So while I was learning from her in a unique way over those years, she was gaining more and more empowerment about her right as a woman to be heard, and that was beginning to carry over into other aspects of her children’s health care with pediatricians and emergency room visits . . . I think she was learning through the relationship that we had over time that not only was it her right, but she should demand to be listened to and was becoming a very strong woman.

In completing our description of the theme of life journeys, we have chosen one story that provides a sense of understanding of the potential for short- and long-term outcomes and effects of care. The midwife cared for a young woman many years ago, facilitating her family’s presence in a hospital setting not particularly conducive to family birth. Other than that, she did not recall a great deal about the birth. Sixteen years later, a young man walked into her clinic with his aunt and requested to see her.

After so many years I had forgotten this lady. His mom had developed breast cancer and she had died. One of the things she had asked was to come find me and go over the story about how he was born. So we sat in my office and cried and told him the story of how he was born. It’s amazing to me that someone should remember you so many years later.

As the midwife recounted this story, she became emotional about the impact this had on the woman and her family, and on herself. The researchers hearing the story had a glimmer of the midwife’s skill as she “midwifed” the young man and his aunt in their grief and loss, and marveled at the mother’s wisdom in sending him back to his birthroots for solace. The midwife’s emotion in the telling of the story was, in part, the realization of how little is known about the potential impact of a clinician’s actions on a person’s life memories. It also helped us to identify that life journeys and outcomes are also experienced by the midwife.

These three overarching themes provide us with a sense of the complex and intricate nature of midwifery practice and its short- and long-term effects. Figure 1 portrays these conceptually to reflect the multifaceted processes and interconnectedness of midwifery care “with women for a lifetime.”

DISCUSSION

These stories have provided a robust portrayal of midwifery practice. The first research question asked what processes of care and beliefs were central to midwifery practice. Two of the three themes identify essential processes of midwifery practice. The mutual relationship between the midwife and the woman provided the foundation for the midwife to orchestrate care to meet the woman’s needs. The second research question asked what linkages there might be between care processes and short- and long-term outcomes for the woman and her family. We believe the identification of the third theme—life journeys—demonstrates there are specific outcomes related to how care is provided and can be measured. Story after story reflected women’s sense of safety, accomplishment, power, and at times, transformation.

The themes are multidimensional and complex. Gesler and Kearns22 use “cultural geography” to examine the concepts of place and space and their relationship to health and health behaviors. They describe a “therapeutic landscape” as one that incorporates the environment, social constructs, and beliefs about health and healing properties. That framework aligns with the themes we identified from the narratives. The relationship between the midwife and the woman could be described as the bedrock of the landscape. Orchestration of an environment of care might be seen as navigating the terrain with the woman. Finally, the “life journeys” could be seen as the horizon, or the future.

Mutuality emerged as foundational in the first theme, implying a relationship of equality between the midwife and the woman. We would propose that the narratives in this study reveal an “engaged presence” in which the midwives gather astute observations, but we believe the woman’s knowledge and a subjective stance make it possible to more fully understand the situation. For example, the midwife who asked the woman “what is standing between you and having this baby?” had clinically observed a stalled labor, but also knew the answer for its protraction may lie with the woman. This is a different position from the objective “clinical gaze” of modern medicine described.
by Foucault. This application of shared knowledge and engagement may be key in understanding how midwives achieve positive outcomes. As many of the stories portray, establishing a relationship with a woman and discovering her world and worries may alter a labor, create a lifelong memory, or help her find her inner strength. Melender and Lauri found this in their work with women’s fears surrounding pregnancy and birth. Rather than protecting a woman from her fears, they emphasize the importance of giving her the opportunity to deal with them.

The second major theme was the orchestration of an environment of care to meet the woman’s needs. We believe this theme is the most complex and little acknowledged in today’s health care arena. Metaphorically, we likened this to an orchestra, in which the conductor (midwife) must know the musicians (woman/family), score (fundamental knowledge), technical supports (staff), and acoustics (health care setting/policies). The midwife draws on the strengths of all, blending and highlighting as needed, but in the end it is the musicians who perform and make the real music. In this respect, it moves beyond the notion of navigation, “to manage, steer or control,” to the ability to combine various elements harmoniously.

In the prior Delphi study, the midwives believed that it was important to “create a respectful setting.” The findings from this study clarified the intricate ways in which they did this. We saw repeatedly in the stories the midwife assess and orchestrate the environment by creating emotional and physical space to help the woman achieve her desires. Emotional space gave a woman time to talk through her fears, or to work through a painful memory. Physical space sometimes just meant the removal of scary medical equipment; regardless, the space felt safe to the woman. These concepts are also seen in Abel and Kearns’ study exploring geographic perspectives of birth places.

Using narratives, they found that women who gave birth at home believed they had more control, continuity with their provider, and familiarity with their surroundings. The last theme portrayed the outcomes, or what we chose to call “life journeys,” for the woman and the midwife. In the past Delphi study, the highest ranked identified outcome was “optimal health of the woman and/or infant in the given situation.” Neither this nor the other identified outcomes in that study conveyed the potential for lifelong memories and effects of the pregnancy, labor, birth, and care experiences that were evident in this analysis. Simkin has done significant research in describing long-term birth memories for women. She found that women with the highest satisfaction with their birth experience believed they had accomplished something important, were in control, and that these were related to their self-confidence and self-esteem. Their memories of the birth were vividly accurate 15 to 20 years after the birth, and negative experiences were rarely shared with the provider.

The ethical schema of care described by Thompson and her colleagues was also evident in the findings. Compassionate care requires a concern and respect for the woman. Perhaps the most profound messages were also the subtest in the realistic approaches the midwives used in caring for women. They did not shy away from the hard questions as they strived to understand someone whose life and desires might be very different from theirs. It takes courage to ask a question for which you may not have an answer, but the asking sends a message of respect, care, and a commitment to work together toward a solution. The concept of competence, or clinical expertise as we conceptualized it, was seen in the midwives’ ability to assess the situation and orchestrate the environment as needed. It was often dazzling and deft. Those are powerful adjectives, but so were the stories and complex maneuvers orchestrated by the midwife to achieve specific and challenging goals with the woman.

The findings of these narratives are similar to van der Hulst and van Teijlingen’s use of stories to describe four aspects of midwives work from the Netherlands, Canada, and the United Kingdom: 1) obstetric technical care (procedures), 2) risk selection for midwifery appropriate clients, 3) social environment (harmonization with the woman’s personal situation), and 4) relational care (provider-client trust based on connection). The resonance of their findings with this study suggests that these dimensions are central to midwifery and may be the differentiating factors from the practice of obstetrics.

Several limitations should be noted with the samples in this study as well as in Kennedy’s prior research. All of the recipients of care who participated in the studies are assumed to have been satisfied with their care; therefore, the perceptions of women who were dissatisfied were not heard. There was also a lack of ethnic diversity among the participants in the studies. The perceptions of ethnically diverse women and midwives are essential to understand what they have to say about midwifery care. Finally, sampling only “exemplary midwives” is problematic by creating the question, what is “non-exemplary?” Future research should focus on all kinds of midwives in all kinds of settings to remove this artificial dichotomy and continue to refine the core elements central to the model of care.

These findings have moved ahead with conceptualization of a model of care reflecting processes of care and effects and outcomes less apparent in prior research. It provides a platform to begin to examine in clinical practice settings and to move toward theory testing. Empirical study should be directed to elucidate the association of relationship between the midwife and woman, specific care processes, and the effect of those on outcomes. Specific questions to consider might include how women perceive their relationship with the midwife and how does that influence her decision making, satisfaction with care, and perception of control during her care experience. How does the belief in normalcy and trust in the woman to give birth translate into the use of technology and its association with perinatal outcomes? Besides the usual perinatal morbidity and mortality indicators, what are other outcomes that should be
examined in relationship to a model of care? These could include maternal role adaptation, self-esteem, childbirth self-efficacy, anxiety, postpartum depression, health care behaviors, and breastfeeding, among many others.

CONCLUSIONS

It is critical that the immediate and long-term effects of midwifery practice be recognized. We are facing monumental challenges in health care today. Our current health care system is struggling to balance rising costs with an ever-increasing reliance on, and demand for, technological innovation. Midwifery care has been demonstrated over and over to be excellent and associated with positive maternal-infant outcomes. This prompts the troubling question: if midwives have such good outcomes, why then are they not the primary provider of women’s health care in the United States? The answers are likely complex but must be explored. It may lie in the often-invisible nature of their work. The midwives in this study were negotiators, not dictators. They believed that power rested with the women and not necessarily in themselves. This does not mean to imply that they were weak or compliant; in fact, they were often the opposite. Yet, their consistent approach in being in a background, rather than a foreground presence may prevent them from being seen as a substantial force for change in our delivery of health care for women in the United States. In addition, emphasis on presence and relationship, rather than routine use of technology, may be misaligned with an institutional and consumer fascination with machines as the solution to achieve optimal birth outcomes. In this study, the midwife represented the “instrument” of care. It was the midwife’s ability to communicate, engaged presence, and clinical judgment that presided, not the technology that was used. Consequently, strategies must be developed to document midwifery care and outcomes in ways that are understood from public health, consumer, marketing, and economic perspectives. Their invisibility as a strategy to help women realize their own strength is admirable, but they must work to increase their public visibility if they are going to continue to make a difference in the lives of women.

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