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UNIVERSITY OF ALBERTA

THE EXPERIENCE OF CHOOSING A MIDWIFE

BY

ANNITA JOY DAMSMA

A THESIS SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES AND RESEARCH
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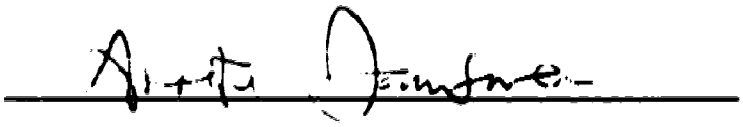

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE EXPERIENCE OF CHOOSING A MIDWIFE submitted by ANNITA JOY DAMSMA in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

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Professor M. Joyce Relyea

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Dr. Brenda Munro

DATE: 24 January 1996

DEDICATION

This thesis is dedicated to
the midwives described within these pages
whose names were not used but
whose actions and words will always be remembered

and to

the women who took the road less travelled.

STRACT

The pu udy was to examine factors that influence t eek a midwife as an alternative to conventiona are. Midwives will soon become regulated ssionals in the province of Alberta. However, wc ons for and experience of choosing midwives as ive practitioners have not been studied in a system- ner. The primary research question was: What is women's experience of choosing a midwife?

The project framework was a qualitative exploratory design using ethnographic methods which resulted in a 'thick' description of the experience of choosing a midwife. Open-ended, semi-structured interviews were the primary source of data and were retrospective in nature. A non probability, purposeful sample was selected from women who had recently experienced midwifery care. The informants were 12 women who had received primary care by a midwife or team of midwives in 1992. Six of these women gave birth at home and six in hospital. Women were cared for by midwives working either within domiciliary group practices or a hospital-based demonstration midwifery project.

Through data analysis common themes regarding the context of choice and the perceptions of midwifery care were identified. Shared beliefs about childbirth, the reactions of significant others and the location of birth were perceived as important influences in the intentional and active process of choice. The relationship between a woman and her midwife emerged as a central theme and was characterized as family-oriented, wholistic, woman-centred, ongoing and one of trust and depth. All informants described positive psychological outcomes including confidence, increased responsibility for health care and empowerment. The informants were unanimous in their belief that midwifery should be an available choice for all women,

regardless of practice setting. It is evident that these women valued an ongoing and personal relationship with known caregivers. In this study insights are provided into consumers' choice of a non-traditional caregiver and facets of the unique midwife-woman relationship are examined.

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I would like to acknowledge some of the many people who have been influential in the process of completing this thesis project.

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Finally but most importantly I wish to acknowledge God my Heavenly Father. It is only through His power and grace that this work was brought to completion.

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The Experience of Choosing a Midwife

CHAPTER I - INTRODUCTION

Throughout most of human history, childbearing women have traditionally been attended by other women. Some of these women came to be known as midwives, which is an Anglo-Saxon word meaning 'with woman' (Flint, 1986), and which signifies the essence of midwifery. In early settlements of North America women practicing as midwives were valuable members of their communities (Mason, 1988; Relyea, 1992). However, the rise of obstetrics and hospital-based practice paralleled the fall of midwifery as medical knowledge expanded and childbirth was viewed as "a medical condition fraught with danger" (Mitchinson, 1991, p. 162). By the twentieth century almost all births were attended by physicians, usually obstetricians, in hospital settings (Leavitt, 1986). This and many historical and social factors contributed to the fact that midwifery did not become a recognized profession in Canada.

Since the 1970's, the combined efforts of the feminist, consumer and alternative birth movements have advocated for increased control by women and families in the birth process and a return to less medicalized birth (Mathews & Zadak, 1991). Many supporters of these social movements recognized the value of the midwife in their goals and beliefs. As consumers, specifically women, have begun to have a voice in the provision of health care a demand has been created in Canada for the option of midwifery care. What distinguishes midwifery care from conventional care? What is it that women believe midwifery care can provide? Or is midwifery care sought because it is the only source of help available outside the hospital setting?

It was anecdotal accounts by women of their homebirths which provided the impetus for this study. These stories

piqued the researcher's interest as to why people would seek such a radical alternative to the accepted standard of hospital birth. Over time descriptions in the literature have identified the typical couple choosing homebirth as well-educated, informed consumers of health care, and as seeking more choice and personal control than may be found in many medical institutions (Schneider & Soderstrom, 1987; Searles, 1981; Tyson, 1991). These descriptions of the characteristics of people choosing homebirth did not satisfy the antecedent, fundamental question as to why they sought an alternative to conventional birth.

Until recently, midwifery was not legislated in Canada and thus a midwife's practice consisted of attendance at homebirths, and concomitantly, homebirths were attended primarily by midwives. It is therefore difficult to separate the choice of birth place from the choice of caregiver. While the two phenomena seem to occur simultaneously, and both are alternatives to medically-oriented childbirth in hospitals, they are not equivalent. Therefore literature on homebirths was not satisfactory in revealing the reasons for choosing a midwife as caregiver.

Much of the literature on birth alternatives including midwives has been anecdotal and descriptive in nature. Research studies on midwives and their practice, the choice of a health professional for maternity care and related topics were examined but scientific literature on the choice of an alternative caregiver was scarce and tended to be dependent on geographical setting.

The province of Alberta has recently regulated the profession of midwifery under the Health Disciplines Act in accordance with recommendations from the Midwifery Services Review Committee (Government of Alberta, 1992). A consumer-based task force and the provincial midwifery association have been instrumental in attaining this legislation. Currently, the Midwifery Regulatory and Advisory Committee

(MRAC) is examining issues regarding the regulation and implementation of midwives into the existing health care system.

A group of practicing domiciliary midwives compiled statistics from 1980 - 1992 describing the births they attended (With Woman Midwifery Care, 1993). During these years, the group attended 1196 births, with an average of approximately 100 annually since 1982. A tertiary care centre in a large urban setting initiated a hospital-based midwifery demonstration project in 1991, which has been involved in approximately 120 births since its inception. (personal communication, Jan. 10, 1994). Although midwifery has not been a recognized profession until recently and is not yet regulated, women are availing themselves of midwifery services. It is the experience of choosing a midwife in this socio-political climate which is the focus of this study.

Statement of the Problem and Research Question

The needs and desires of consumers of maternity care must be sought in determining the scope of practice for midwifery. Given the current stage of midwifery legislation in Alberta, this study is appropriate as the findings will provide data which may assist in the development of a context for the implementation of midwifery. Thus, the need for such a study is substantiated. The purpose of this research study is to describe in detail women's experience of choosing a midwife for maternity care, including their reasons for choice. The principal research question is: What is women's experience of choosing a midwife?

Significance of the Study

The factors that influence women's choice to step outside the conventional health care system to seek the alternative of midwifery care have not been adequately explored, especially in a Canadian context. In defining midwifery care and justifying midwives' scope of practice, one must know what clients value in midwives and their care, and seek to document and enhance those qualities. Now that midwifery is a designated profession in Alberta, the characteristics that differentiate it from conventional maternity care, and the reasons for seeking such care must be determined from the women who choose this alternative. This study will provide insight into the experience of choosing a non-traditional caregiver and women's perceptions of midwifery care.

In the following chapters, the research study will be outlined as it progressed. Chapter II contains a review of literature relevant to the research question and provides additional rationale for the study. Chapter III is the section on research method, which includes information on the sample, data collection and analysis, rigour and validity and ethical considerations. The findings are presented in Chapter IV which contains extensive quotations from the informants. Chapter V concludes the study with a discussion of the findings, as well as its implications for clinical practice, research and education.

CHAPTER II - REVIEW OF THE LITERATURE

Introduction

A literature review was conducted to examine previous and related research and to guide the researcher in determining the specific method of inquiry in studying the research question. Relevant literature was analyzed in terms of content, underlying assumptions, biases, and context of the study. This method allows the researcher to be informed, yet does not limit or bind the current analysis (Field & Morse, 1985). Following the analysis, more recent literature was examined and incorporated into the review.

For the purposes of this research study, literature from a variety of sources was reviewed. Most of the literature presented below summarizes findings from qualitative and quantitative research studies and government and health policy statements. While non-academic references were helpful in understanding the larger issues, the focus of this literature review is primarily scientific research.

Literature pertaining to the history of childbirth and midwifery in North America will be presented to place this study within a historical and social context. The concept of choice will be examined in order to more fully understand what is meant by the term choice. This will be followed by quantitative and qualitative studies on the phenomenon of homebirth, research on choosing a caregiver for maternity care, literature about midwives and their practice, and finally documentation specific to Canada, Alberta and the current socio-political health care situation.

Historical Context

During the eighteenth century, in the new colonies of Canada and the United States, midwives were valuable practitioners, often the only source of health-related and

medical knowledge in their communities (Leavitt, 1986; Mason, 1988; Relyea, 1992). These women were rarely midwives by profession, but simply women who met the need for care during the birth process. However, this birth culture of family and neighbour involvement deteriorated as the new world became more populated. Industrialization may have been one factor leading to the breakdown of the mutual aid birthing network of women (Relyea, 1992).

In the mid-nineteenth century, with the techniques of forceps-assisted delivery and inhalation anesthesia, childbirth began to be attended by male physicians who controlled these techniques. These physicians initially attended women at home and were sought only for complicated births requiring intrusive measures. Many historians propose that the relocation of birth from home to hospitals was the most influential factor in the progressive medicalization of childbirth (Leavitt, 1986; Mason, 1988; Mitchinson, 1991; Relyea, 1992). While hospitals were initially intended for the lower-class; middle-class women became intrigued with the promise of scientific, painless and antiseptic birth in an institution (Mitchinson, 1991). Leavitt (1986) argues that women's attraction for hospital births and the promises they offered were well-founded because for many females in that era, pregnancy and birth were indeed hazardous conditions. Slowly, the majority of births in North America took place in hospital with physicians in attendance. Leavitt (1986) refers to the experience of women leaving their homes to give birth in medical institutions as being "alone among strangers." (p. 171).

There are several sociological movements which have mitigated against medical control of birth in current society - the feminist, consumer and alternative birth movements (Barrington, 1985; Mason, 1988; Mathews & Zadak, 1991). The sexual revolution and feminist movement

empowered women to make their own reproductive choices. Initially, feminist and women calling for choices in childbirth were at odds. Feminists were trying to release women from their biological imperative to bear children and were opposed to those advocating motherhood. However, "the feminist understanding of the mid-1980's was ready to embrace a concept of choice that included choices in childbirth.." (Barrington, 1985, p. 153).

The consumer movement in health care involved questioning physicians, seeking second opinions, shopping for medical services and various self-help programmes (Mathews & Zadak, 1991). Many parents in this generation were older, more educated and availed themselves of the plethora of literature on health, including birth and parenting. There was a general awareness and interest among consumers with regard to their health and less faith placed in the medical profession.

The alternative birth movement in North America has been described as a reaction against the medical establishment which has controlled obstetrical care (Mathews & Zadak, 1991). Many people in this movement espouse holistic care, healthy lifestyles and the spiritual and social aspects of birth. Pregnancy and birth are viewed as normal, physiological processes which are to be respected and not manipulated. Many of these people give birth at home, often with midwives in attendance.

The common philosophy uniting the feminist, consumer and birth alternative movements was the reclaiming of control by women/consumers/parents from the paternalism of the medical establishment. Since the 1960's and 70's, consumer groups, health professionals and others have been fighting to demedicalize birth and to reintegrate midwives into maternity care. Davis-Floyd, an anthropologist provides a fascinating comparison of the ideologies of the technocratic/medical and wholistic/midwifery models of

childbirth in her book entitled Birth as an American Rite of Passage (1992). She reflects on the mutual exclusiveness of these paradigms and raises provocative questions about the profound significance of birth within society.

The Concept of Choice

Choice is a fundamental concept to this research study and therefore a concept analysis was carried out by the researcher to delineate its meaning. The concept was analyzed to determine the defining attributes, antecedents and consequences of choice, especially in regard to childbirth. One of the defining attributes of choice is that it is conscious and involves active participation. There is a notion of freedom or power, whether it is self-determined or externally granted. Finally, in order to choose, there must be at least two alternatives from which to choose and one must be aware that these alternatives exist. Thus, the defining attributes of choice are active, free and aware.

The most important antecedent to choice is awareness that it exists. From this point, knowledge about various choices can be gleaned and finally, a choice made. Awareness must precede knowledge which precedes choice. Thus, awareness and knowledge of choice are its antecedent conditions. In a study conducted in Salford, England pregnant women were surveyed about their knowledge of choices available to them. A large percentage were considerably unaware of their options which caused the authors to conclude that "women appear to feel that they are being directed rather than given the information needed to make an informed choice about their care." (Salford Community Health Council, 1992, p. 9). This example demonstrates the need for both awareness and knowledge of available choices. These two conditions may not be sufficient however, if there is not freedom or permission to

make choices. Even if awareness of choice exists, there may be undermining by health professionals or society of women's choices.

Choice is dependent on contextual factors as well as personal ones. Economics, politics and social structures can either limit or enhance the availability and awareness of choice. Personal factors such as one's education, values and beliefs, the assessment of risks and locus of control are considered important determinants of choice (Bassingthwaite-Thiessen, 1988; Cunningham, 1993; McClain, 1981; Murphy & Harvey, 1989; Schiff & LaFerla, 1985).

The consequences or outcomes of choice may include satisfaction, accountability or a sense of personal responsibility and increased confidence in oneself (Cohen & Estner, 1983; Mertick, 1991; Simkin, 1991; Sullivan & Beeman, 1982). The positive outcomes related to choice are often strongly dependent on the care given to women during their childbirth experience. Therefore, the concept of choice as it relates to women's experience of childbirth is a topic worthy of further study.

Finally, choice is regarded as an ongoing process, as opposed to a decision, which refers only to the outcome or culmination of choosing. In a study on the experience of preterm labour, the choice to seek care was viewed as "a process, not a static decision, that situationally unfolds and takes a variety of paths." (Patterson, E., Douglas, Patterson, P. & Bradle, 1992, p. 367). Choices in childbirth also evolve as one receives and processes new information which may cause attitudes to be strengthened or rejected. One research study was found that examined decision-making regarding childbirth prospectively (Schiff & LaFerla, 1985) but studies on childbirth are most often carried out retrospectively in order to capture the experience in its entirety.

Homebirth Studies

Quantitative Research

As most midwifery care to date has been associated and carried out in client's homes, a review of the literature on home birth was conducted. A large portion of this literature was focused on objective measures which assessed physical outcomes of both mother and child, ie. maternal and neonatal morbidity and mortality, with regard to the safety of home birth (Anderson & Greener, 1991; Schneider & Soderstrom, 1987; Tyson, 1991; Woodcock, Read, Moore, Stanley & Bower, 1990).

Differences exist in health care systems around the world, but results of a recent Canadian descriptive study of 1001 planned, midwife-attended homebirths characterized the Toronto homebirth population as having a high rate of spontaneous vaginal births and low maternal morbidity and neonatal morbidity and mortality (Tyson, 1991, p. 18). Researchers in Texas conducted a descriptive analysis of homebirths attended by nurse-midwives and demonstrated similar favourable outcomes (Anderson & Greener, 1991). Findings from studies such as these have caused researchers to conclude that homebirth may be a safe option for selected low-risk populations.

Both the safety of home births and midwives' association with them continue to be controversial for many reasons and have been the subject of heated debate, especially within the medical profession (Brown, 1987; Child, 1990; Dixon, 1987). Although several well-conducted studies have demonstrated that planned homebirths attended by trained practitioners are at least as safe as homebirths for selected populations, the issue remains a contentious one, often based on philosophical differences rather than scientific evidence (Campbell & MacFarlane, 1990; Hoff & Schneiderman, 1985).

In many developed countries, homebirths represent only small percentages of total births - approximately 2-3% in the United States (Schiff & LaFerla, 1985), 1% in Britain (Fleissig & Cartwright, 1992), 0.5% in Australia (Child, 1990) and 0.4% in Canada (AARN, 1991). The small numbers of homebirths make comparison and generalization difficult but these numbers are rising in Australia (Woodcock, Read, Moore, Stanley and Bower, 1990) and perhaps other countries as well. Research on homebirth outcomes, although necessary, does little to answer the underlying question of why people are rejecting established forms of care and opting for this alternative.

Qualitative Research

Qualitative studies on homebirth provided data on the characteristics of people choosing homebirths, their reasons for making such a choice and key issues relating to the choice of home as a birth place. Many of these studies were descriptive in nature and assessed 'soft' outcomes such as satisfaction, and examined psychological constructs including one's locus of control and attitudes. Studies on homebirth in Canada, the United States, Britain, Australia and New Zealand presented similar data across geographical settings (Abel & Kearns, 1991; Bassingthwaite-Thiessen, 1988; Cunningham, 1993; Searles, 1981; Schiff & LaFerla, 1985).

Some researchers compared alternative and conventional birth places, with alternatives including birth centres as well as home settings. Issues such as control, choice, continuity of caregiver, and concepts such as birth being a natural process and a family event were identified as important in the choice of an alternative birth place (Klee, 1986; Searles, 1981). In a number of studies, subjects were asked to name and/or rank their reasons for choosing the place of birth. Common reasons cited were the ability to be in control, birthing in a comfortable and familiar

environment and the desire to have family members present (Schiff & LaFerla, 1985; Searles, 1981; Shepperdson, 1983).

A qualitative study conducted in New Zealand (Abel & Kearns, 1991) indicated that the choice of home as a birth place was related to three dimensions of experience: control, continuity of care and place, and the familiarity of home. These themes were elicited from six women via several informal, in-depth interviews, and provided rich data on the choice of home as birth place.

In a correlational study conducted in Alberta issues of control were compared between women giving birth at home and women birthing in hospital (Bassingthwaite-Thiessen, 1988). The researcher found that women having home births tended to have an internal locus of control and stronger attitudes about issues of choice in childbirth than the hospital group. Annandale (1987) explored the phenomenon of patient control in a birth centre in relation to choices in childbirth. The concept of control seems to be important in choosing the site of birth, but whether it influences the decision for midwifery care remains unknown.

In an Australian study (Cunningham, 1993), 395 women completed questionnaires which included the Health Locus of Control Scale (HLC) and the Women in Society Questionnaire (WSQ) which assessed gender roles and values. Homebirth mothers were found to be more feminist and more willing to accept responsibility for their own health, which was reflected in a high internal score on the HLC. The author concluded that women's childbirth experiences are consistent with their ideologies.

Canadian researchers carried out a survey of interest in alternative birthplaces with 1115 women in the Ottawa-Carleton region of Ontario (Soderstrom, Stewart, Kaitell & Chamberlain, 1990). Their results indicate that 15.2 % of respondents would be interested in a birth centre and 2.8% would choose homebirth. The authors realize that while such

a survey has limitations it does indicate a level of interest in alternative birth places. Because homebirth is not yet an accepted alternative in Canadian health care, it is difficult to assess preferences. In a British medical journal, the comment was made that "realistic comparisons of preferences will be possible only when more women give birth at home." (Fleissig & Cartwright, 1992, p. 476.)

Qualitative research on the topic of homebirth has revealed several attitudes and values of people choosing to give birth in an alternative setting. Issues such as choice, control and continuity of care and certain ideologies about medicine, childbirth and gender roles seem to be important components of this decision. Many women who choose to give birth at home are attended by midwives; however, the research and findings related to homebirths may not directly apply to the choice of a caregiver.

Research on Maternity Care Providers

Several studies have provided data on the choice of various caregivers involved in maternity care including obstetricians, family physicians, midwives, nurse-midwives and nurses. Research has been both qualitative and quantitative in nature and has assessed such items as satisfaction, physical outcomes, preferences and the congruence between client and caregiver. In an American study on how parents selected obstetricians, it was found that effective communication was the most important factor in selecting a caregiver (Brien, Haverfield & Shanteau, 1983). Top ranking by both fathers and mothers was given to items related to their opportunity to ask questions and the physician's ability to listen to and answer questions.

In a Canadian study conducted in British Columbia, prenatal care given by nurse-midwives and family physicians was compared on several physical outcome variables (Buhler, Glick & Sheps, 1988). Through chart review of 132 subjects,

they concluded that nurse-midwives provided prenatal care to low-risk women that was "comparable, if not superior, to the care provided by family physicians." (p. 397). While this study did not assess women's choice of a caregiver, it provides evidence for the quality of midwifery care. In a more general article written about the same nurse midwifery project, the authors received positive comments from their clients in regard to the quality and sensitivity of the care received from the midwives (Weatherston, Carty, Rice & Tier, 1985).

Choice of Health Care Professional

Aaronson (1987) examined the 'fit' between models of care and clients who chose either obstetricians or nurse midwives. She found that nurse-midwife clients scored higher on internal locus of control than the clients of the obstetricians. It was concluded that the 'fit' or congruence of beliefs between client and caregiver was more important than the content of those beliefs. In other words, similar ideologies seemed to be a very significant factor in one's choice. The author also indicated a need for further research into women's informed choice of a maternity care provider.

One Canadian study was found that addressed women's choice of health professional for maternity care. The research was conducted in Ottawa, Ontario and consisted of a self-administered survey questionnaire, completed by 1115 women who gave birth in the summer of 1987. It was found that "59.9% of the respondents were interested in some form of midwifery care, and 11% would have liked complete primary midwifery care for this baby." (Stewart & Soderstrom, 1991, p. 1597) This study, while lending support for midwifery services, was a general survey of interest, and did not explore the reasons for women's choices. It is of note that it was conducted prior to legislation establishing midwifery as a recognized health care profession in Ontario and

therefore prior to midwives becoming accepted practitioners.

Satisfaction with Caregivers

While satisfaction with childbirth is a complex construct which is difficult to identify and measure, nonetheless, studies of parental satisfaction have provided useful information on the desired quality and type of care during the childbearing process. These studies have primarily assessed satisfaction with the birth experience, with the caregiver being only a part of the total event (Bramadat & Driedger, 1993; Chute, 1985; Green, Coupland & Kitzinger, 1990; Morcos, Snart & Harley, 1989; Sullivan & Beeman, 1982). The relationship between a woman's expectations and her actual experience seems to be important in determining her satisfaction with childbirth.

Cunningham (1993) measured women's satisfaction with caregivers (doctors and midwives) as well as their partners. Through regression analysis, he found that the importance of the sex of the midwife, the proportion of time spent together and the belief that the place of birth affected bonding were predictive of satisfaction with the midwife, while birth venue significantly predicted satisfaction with the doctor. It is interesting that predictors of satisfaction varied with different caregivers, implying that women somehow viewed their roles as separate and distinct.

Field (1985; 1987) studied parents' reactions to maternity care provided by nurses in different hospital settings. It was found that care was generally satisfactory during labour, but nurses were perceived to be less supportive and responsive during the postpartum stay. She concluded that satisfaction was optimal when nurses treated parents with respect, kept them informed of their progress and created a feeling of confidence in their care.

While no systematic studies were found that measured satisfaction with midwives specifically, anecdotal and descriptive literature abounds with parental praise for

midwives and their care. Many families state that the hallmark of the exemplary care received is the personal and supportive nature of the midwife-client relationship (Barrington, 1985; Flint, 1986; Hanley, 1993; Hutton, 1988).

Midwives and their Practice

Research on midwifery practice varies greatly depending upon the setting in which the study was conducted. There are significant differences in the level of research conducted in the United Kingdom where midwifery has always been recognized and practiced; America, where midwives have been actively practicing in some states and are outlawed in others; and Canada, where midwifery is in its infancy. Models of midwifery care are also somewhat dependent on location, with the United Kingdom model being rather fragmented. In most cases, midwives practice primarily within one setting - antenatal clinics, labour and delivery, postnatal wards or the community. However, steps to promote continuity of care are being taken, most notably the Know Your Midwife scheme (Flint & Poulengeris, 1986) and the recent report of the House of Commons Select Committee on Maternity Services (1992).

In the United States, where certified nurse-midwives (CNMs) have been practicing for some time, there has been some research and description of the content and process of midwifery care (Lehrman, 1981) and a preliminary model of midwifery care has been proposed (Morten, Kohl, O'Mahoney & Pelosi, 1991). This model identifies the themes of empowerment, lateral relationship and therapeutic techniques as integral and related components in midwifery care. Other identified components include continuity of care, family-centred, non-interventionist, flexible and participative care, consumer advocacy and time (Lehrman, 1981). Lehrman has further developed these components into a theoretical framework for nurse-midwifery practice.

Researchers in the United Kingdom have examined midwives' underlying philosophies of their practice (Todman & Jauncey, 1987). Midwives' attitudes were classified as 'patient-centred' in regard to women's rights, women's preferences and women's control in decision making. In another large study midwives' perceptions of therapeutic midwife-client relationships were identified (McCrea & Crute, 1991; McCrea, 1993). Four factors which affected the midwife-client relationship were the nature and value of the midwife's role, recognition of her autonomy and authority, emotional involvement with clients and maintaining personal integrity. These studies were based on the perspectives and data of the midwives themselves, and may or may not reflect the women's perceptions of their care.

Because midwives have only recently been accepted as legitimate health care professionals in Canada, description of their practice is frequently focused on outcome variables. Several research projects have been established to study midwifery care in hospital settings. In Ontario, a midwifery service was evaluated on intrapartum outcomes and demonstrated significant reductions in the frequency of amniotomy, epidural and episiotomy and significant increases in the use of non-pharmacological pain relief methods and the occurrence of lacerations (Kaufman & McDonald, 1988). An article written for the national nursing journal in Canada provided some insight into the rising popularity of midwives (Hanley, 1993). Continuous, personal and sensitive care and the equality of the midwife-woman relationship were mentioned as advantages to choosing midwives. This article was general in scope and did not employ a specific research method, but raises awareness and provides an overview of midwifery care in a Canadian setting.

In New Zealand, Bassett-Smith (1988) developed a grounded theory on the relationship between midwives and the woman for whom they care in which the process of

authenticating emerged as the central theme. Authenticating included the phases of making sense, reframing, balancing and mutually engaging. The author states that her conceptual framework legitimizes 'being with' women and facilitates a woman-centred approach to care (p. 1). This was the only research study that was identified which examined the perspective of both the midwives and the women and viewed the relationship as a whole.

Current Canadian Developments in Midwifery

Canada has been hesitant to legislate midwifery as an autonomous health profession and was the only industrialized nation which did not have legislation supporting midwifery practice (Burtch, 1987). However, the governments of Alberta, British Columbia and Ontario have each taken steps to this end. Many recommendations for implementing midwifery in the Canadian context were presented in the Report of the Task Force on the Implementation of Midwifery in Ontario (1987) which examined midwifery practice in several European countries and the United States.

In November of 1991, Ontario formally recognized midwifery under the Regulated Health Professions Act and as of January 1994, midwifery services are provided for under provincial health care (personal communication, Ontario Association of Midwives, Jan. 5, 1994). In June of 1992, the province of Alberta recognized midwifery as a distinct health profession under the Health Disciplines Act, followed by British Columbia in May of 1993. In Alberta, the Midwifery Regulatory and Advisory Committee (MRAC) has been meeting in order to develop final recommendations regarding the implementation of midwifery into Alberta's health care system and plans to release a document in spring of 1994.

Decisions regarding midwifery have been made in the context of diametrically opposed views. While the Canadian Medical Association has stated that the "Canadian obstetric

care system (is) among the finest in the world" (Sullivan, 1987, p. 643) much of the lobbying for midwifery legislation has been from consumers, who are obviously seeking alternatives to conventional obstetric care. As an example, the Alberta Health Disciplines Board (1991) received 242 letters from individual citizens in response to their investigation of midwifery - 238 of these were in favour of legislative recognition. Task forces consisting of consumers of maternity care have been significant forces behind midwifery legislation in several provinces, including Alberta.

Conclusion

A review of the relevant literature was undertaken to determine the nature of the existing knowledge on midwifery care in various countries, with specific interest in Canada. Within the last two decades, there has been a resurgence of interest in midwives and alternative birth practices in North America. The phenomenon of homebirth has generated research studies from a number of disciplines which examine epidemiological and sociological issues, among others.

There is a small body of research being conducted in an attempt to explicate the underlying attitudes and philosophies of midwifery care and the way in which midwives practice. However, much of this literature is based on the perspective of the midwives and the nature of the midwife-client relationship, not on a woman's reasons for seeking this alternative form of care. In fact, no research studies were found that described in any depth why women chose the services of a midwife for maternity care in a Canadian setting. It is evident that women are interested in midwifery care, and some are presently obtaining midwifery services, but the reasons for seeking such care have not been adequately explored.

CHAPTER III - METHOD

Rationale

The purpose of this research study was to generate a thick description of women's experiences of midwifery care, including reasons for choice and perceptions of the care received. It is important to choose a research design which is most appropriate for the research question and the population under study. A qualitative, exploratory design was the framework used to guide this study.

Qualitative methods are most suitable to explore and describe a phenomenon from an emic perspective, that is, the perspective of the person experiencing it (Field & Morse, 1985). Based on a review of the literature, there is little known about the research topic. An exploratory design is appropriate when studying a topic not previously studied in a particular population, which is true of the women choosing midwives in Alberta at this time. This being the case, an exploratory, descriptive study using ethnographic methods was appropriate as an initial inquiry into the phenomenon (Field & Morse, 1985).

Ethnographic methods such as personal interviews, field notes and participant observation are used in developing thick descriptions. Because the informants were describing their experiences retrospectively, participant observation was not possible; however, Fetterman (1989) states that "the interview is the ethnographer's most important data gathering technique." (p. 47). Personal interviews were the primary source of data and guidelines for conducting ethnographic interviews were reviewed and utilized during data collection. All interviews were audio-taped and produced a large amount of transcribed data for analysis.

Definition of terms and descriptions of the sample, methods of data collection and data analysis which were used

in this study are outlined below. Ethical considerations and a discussion of the study's rigour and validity are also addressed.

Definition of Terms

It is inappropriate to use a standard definition of a midwife for the purposes of this research. Midwives in Alberta do not yet have a common accepted program of study or apprenticeship, or standards of practice; therefore midwifery essentially remains an unregulated profession with individual midwives defining their role and scope of practice. Those practicing midwifery at the present time are either nurses who have apprenticed with a physician or other midwives, or nurses who have completed an educational program in midwifery care.

In order to seek midwifery care, a woman must have some perception of what a midwife is and what kind of care she can give. It is this perception that will be sought from the women, and thus, a midwife will be defined by the women who seek her care.

Maternity care is defined as: the supervision, care, and advice to women and their families during pregnancy, labour and the postpartum period, ie. ante-, intra- and post-partum care.

The Sample

Appropriateness

The appropriateness of a sample in qualitative research refers to "the degree to which the choice of informants and method of selection 'fits' the purpose of the study as determined by the research question and the stage of the research." (Morse, 1991, p. 134). The sample for this study was a non-probability, purposeful sample, in which informants were selected according to the needs of the study (Morse, 1991). In the present socio-political context, the choice of a caregiver and the choice of birth place are closely linked; therefore women who had chosen midwives to

attend them in both home and hospital settings were sampled. This type of sample was chosen to ensure that the choice of a midwife, regardless of setting, was the topic being studied and explored. Informants with a broad, general knowledge of the topic and whose experiences were considered typical were interviewed initially, followed by those who had knowledge of more specific experiences.

Initial inclusion criteria for the study were:

a) prenatal and postnatal care by a midwife or group of midwives,
b) birth attended by a midwife/midwives,
c) birth of a healthy, live infant within the previous 2 to 12 months,
d) ability to speak and understand English, and
e) cognitively able to reflect on and verbalize experiences related to the topic.

These criteria and some modifications on them will be explained below.

There are some women who have a midwife attend their births as the labour support person only. Because these women do not choose midwives as primary and independent caregivers for their pregnancy and birth, they were to be excluded from the sample. There was one informant who was an exception to this criterion but her data were included as representing a somewhat atypical case. Using the time frame of 2 to 12 months following the birth recognizes that midwifery care may extend 6 or 8 weeks postpartum; therefore interviews would take place after care had been terminated, and hopefully before another pregnancy occurred. Some informants were interviewed after the 12 month point, which was initially selected as an arbitrary limit. However, it has been demonstrated that many womens' birth memories are very vivid, and able to be accurately recalled long after the experience (Simkin, 1992). All informants were interviewed within 14 months of their last birth experience, and all births took place within the year of 1992. Informants who were able to reflect and provide experiential

information about the topic were crucial to the quality of the research.

Sampling occurred concurrently with data collection and analysis, which allowed the researcher to select informants to fill in identified gaps in description. The present general situation in Alberta is that midwives in one major city practice independently and attend primarily home births, and those in another city work primarily within an institution. Informants were selected from two group domiciliary midwifery practices in one major city and a hospital-based midwifery demonstration project in another.

Access Procedures

While the primary method of sampling was purposeful selection, there was an element of self-selection by potential informants. Women who were interested in sharing their experiences of maternity care by midwives responded to the researcher in one of two ways - via telephone or response letter. Each of these procedures will be described fully.

An advertisement (see Appendix A1) with the researcher's phone number and a brief description of the purpose of the study was posted in both domiciliary midwifery practices in one city. This advertisement also appeared in a spring 1993 issue of the Alberta Midwifery Task Force newsletter, a publication for consumers of maternity care throughout the province. Interested women then phoned the researcher and were given further information about the inclusion criteria, the requirements and time commitment of the study. If a potential informant suited the needs of the study at that time, (according to the principle of purposeful sampling), and gave preliminary verbal consent, an appointment for an interview was made. Written consent was obtained at the time of interview. Fourteen potential informants contacted the researcher in

this way and nine of them were selected as primary informants.

Most women who contacted the researcher by phone had experienced midwife-attended homebirths. In order to ensure that the sample addressed the choice of a midwife rather than the choice of a homebirth, more informants with midwife-attended hospital births were sought to add breadth to the data. Three of the nine informants had experienced hospital births; two were participants in the hospital-based midwifery demonstration project who had contacted the researcher of their own accord.

Assistance was sought from the staff of the hospital-based midwifery demonstration project to interview several more women who had participated in their programme. In order to access this population, ethical clearance from the institution was required and subsequently obtained. A member of the hospital staff sent out information letters (see Appendix A2) to potential informants, who could then return an enclosed postcard to the researcher if they were interested in participating. Letters were sent to ten randomly selected women who matched the inclusion criteria for the study. The researcher received five responses from potential informants and selected three of these as primary informants.

Adequacy

In qualitative research, the principle of adequacy refers to the sufficiency and quality of the data obtained and is assessed by the completeness and the amount of information, rather than by the number of cases (Morse, 1991). It was proposed that twelve to fifteen informants should provide adequate data to answer the research question. In total, twelve primary informants were interviewed who had either responded to the advertisement or to the information letter sent by the hospital delegate. Six informants had given birth in hospital and six at home,

all attended by midwives. Data are considered to be saturated when no new information or themes are discovered in the analysis of interview data (Field & Morse, 1985). The sample of twelve primary informants provided sufficient data for common themes to be identified in analysis.

One secondary informant was obtained later in the study to validate themes and categories which the researcher had identified through analysis. She did not provide any new data, but did validate that the findings 'fit' with her experience of midwifery care. In addition, two primary informants were selected to read a summary of the findings; one from the hospital group and one from the home group. These informants provided verification of the findings and commented on the accuracy of the researcher's interpretation of their experiences.

Data Collection

Interviews

The primary source of data was semi-structured interviews conducted face-to-face with the informants. All informants were interviewed in person once, with follow-up telephone calls made to two informants in order to clarify details from the transcribed data. The option of a second personal interview was proposed but not deemed necessary. All interviews were audiotaped and transcribed verbatim by the researcher.

Interviews were semi-structured and utilized open-ended questions. This technique allowed the researcher to focus on the area of interest, while granting the informant flexibility to describe personally relevant experiences (Field & Morse, 1985). The opening question was quite general, which allowed the informant to explore the topic from her unique perspective, without influence from the interviewer. More focused questions were utilized as needed to provide data in relation to specific areas. (See Appendix D for Interview Guide.) Additional guiding

questions were added at different times during the study. During the pilot interview, extensive data regarding the personal outcomes of choosing a midwife were described, which led the researcher to include a question pertaining to this topic. At other points in data collection and analysis, new questions were added to the interview guide which addressed topic areas described by previous informants.

Fieldnotes and Setting

Fieldnotes were used to supplement interview data and were written by the researcher immediately after completing the interviews, in order to record relevant observations. Comments on non-verbal behaviour, setting and context of the interview and other salient points were recorded and analyzed in conjunction with transcribed data. All interviews took place in the informants' homes at a mutually convenient time. In some cases, there were interruptions from babies, toddlers and pets but all settings were comfortable. Most interviews took place in the kitchen or living room, often over a cup of tea. Some informants were anxious about being audio-taped initially but as the interview proceeded, they seemed to forget that the conversation was being recorded. All informants seemed comfortable with the researcher and non-verbal and verbal behaviours corresponded appropriately.

Other Methods

Since the primary method of data collection was via personal interviews, the researcher herself was an integral part of the data. This interaction between the researcher and the data is referred to as reflexivity (Lipson, 1991), and is inherent in many qualitative research methods. For this reason, the researcher also kept a record of subjective thoughts and feelings during the study to document sequencing of events, thought processes and new ideas.

Keeping this journal was an attempt to identify the researcher's personal biases and assumptions.

Finally, a background data form was completed by each informant which provided structured data on demographic information and childbirth history (See Appendix E). These data were collected at the beginning of the interview. Data from this form also provided pertinent information about the informants which then guided subsequent purposeful sampling.

Data Analysis

Analysis of data overlapped with sampling and data collection methods. Preliminary analysis of early interviews generated new questions and guided purposeful sampling. Data was cross-sectional, derived from informants who had chosen midwifery care in various settings within a particular block of time. Data from all sources ie. transcripts, field notes, research journal and background data form, were analyzed to provide a total picture. All interviews but two were transcribed by the researcher herself, which increased her familiarity with the data. Interview transcripts, field notes and the research journal were examined inductively using analysis methods as described by Miles and Huberman (1984) and the personal data form was analyzed using descriptors such as frequency and range.

The goal of analysis as viewed by Miles and Huberman (1984) is the expression of social regularities "as precisely as possible, attending to their range and generality and to the local and historical contingencies under which they occur." (p. 19) The goal of this analysis was to provide a thick description of women's reasons for choosing a midwife and perceptions of their experiences as they occurred in the current health care context in Alberta.

Data were analyzed using the three-part process as described by Miles and Huberman (1984): first level coding,

pattern coding and memoing. The technique of coding assigns an abbreviation to a group of words with a common meaning, thereby classifying them into categories. Coding is a measure to simplify the masses of raw data into manageable parts for analysis. An effort was made by the researcher to 'ground' codes in the words of the informants, and codes were not constructed 'a priori' before initiating data collection. Each informant's transcript was given a colour which identified the source of the data. These coded segments were then cut and grouped together in pattern codes, and some segments appeared as quotations in the presentation of data.

First level coding was primarily descriptive ie. a phenomenon was assigned a name (code) to describe its attributes. Forty descriptive codes were derived and operationally defined. Descriptive codes frequently referred to the same phenomenon throughout analysis ie. trust was both a first level and a pattern code and data on trust was finally presented in a description of the trusting relationship.

The second step in analysis was pattern coding, in which the researcher moved beyond description to inference and potential explanation of patterns and relationships. Pattern codes act to pull material together into more encompassing themes or constructs. The forty descriptive codes were reduced to twenty-three pattern codes and many of the pattern codes became subtitles in the presentation of data. Two examples follow: the two descriptive codes of confidence and responsibility were collapsed into the pattern code of personal outcomes, and were presented as personal outcomes. The descriptive code of control was related to three areas: location, the role of the midwife and personal control. Control did not remain a code, but was a theme in the findings on the influence of location, woman-centred care and the professional role of the midwife.

The third component of analysis was memoing, which was a technique that captured the researcher's thoughts and ideas which occurred during data analysis. Memos are conceptual in intent (Miles & Huberman, 1984) and provide insight into the evolving themes and their relationships. They are reflective remarks comprised of a few words, sentences or paragraphs that record hypotheses, links and interpretations seen in the data. These recorded ideas assisted the researcher to detect regularities, patterns, explanations and other more conceptual relationships among categories. The three processes of data analysis described above continued until no new categories or relationships were found in the data.

Those women from the hospital-based practice were considered separately from those delivered at home on some questions/data to determine whether their responses were similar to or different from one another. Differences between groups will be described in the findings section and subsequently discussed. The analysis of data provided a rich and integrated picture of why women choose midwives for care and identified common themes about their experiences.

Rigour and Validity

Qualitative research must meet standards of rigour in order to be assessed and evaluated as a form of scientific inquiry. The criteria for assessment of trustworthiness as established by Guba (1981, quoted in Krefting, 1991) for qualitative research were utilized for this study. These four criteria are: credibility, transferability, dependability and confirmability.

The first criterion for trustworthiness is the truth value or credibility of the study. "A qualitative study is credible when it presents such faithful descriptions of human experience that the people having that experience would immediately recognize it from those descriptions as

their own." (Sandelowski, 1986, p. 30). In this study, the validation of data findings with two of the primary informants was the primary strategy to promote credibility.

Generalizability, and therefore external validity, is usually not sought in qualitative research studies. Instead, the data must 'fit' or be applicable to the informants from which they were derived. Applicability was achieved by presenting data which was grounded in the life experiences of all the informants - thick description. The characteristics of the sample were described in relation to the larger population from which it was drawn and informants represented a range of experiences. A secondary informant also found the findings to be applicable to her experience of midwifery care.

The third criterion for trustworthiness is consistency, which is analogous to the term reliability. Research methods were thoroughly described in order that another researcher could follow the steps of this study ie. conduct an audit trail, to arrive at similar conclusions. Consistency was also sought through double-coding, in which the researcher and a colleague coded transcribed data independently and achieved similar results. Discussions with the research supervisor to receive feedback, guidance, and to detect bias were held regularly to assist the researcher in maintaining dependability.

Neutrality or freedom from bias is the final criterion in assessing trustworthiness. This refers to the research findings only - reflexivity and subjectivity are valued and inherent in qualitative approaches (Krefting, 1991). The use of a research journal to record the researcher's potentially biased thoughts separately from the informants' data was a strategy to ensure reporting of unbiased findings. Triangulation of data collection methods (personal interviews plus field notes) added to the study's confirmability.

Other strategies to enhance the trustworthiness of this study were in regard to the 'researcher as instrument'. The interview guide, background data form and logistics of the interview were tested in a pilot interview. This exercise led to a refining of the researcher's interview techniques and the addition of an interview question. In addition, the researcher has a measure of credibility by virtue of her familiarity with the topic under study, strong interest in conceptual and theoretical knowledge, and development of investigative skills through coursework, literature review and related experience. These qualities have been suggested to be desirable in the human instrument (Miles & Huberman, 1984).

Ethical Considerations

Informed Consent

Women who were interested in sharing their reasons for choosing midwifery care could freely respond to the researcher's advertisement or letter (see Appendices A1 & A2) in search of informants. Potential informants were given information about the inclusion criteria, requirements and time commitment of the study. In addition, this information was presented in a letter (see Appendix B) which was read by the informant prior to giving written informed consent, and any further questions were answered at that time (See Appendices C1 & C2 for informed consent forms). The information letter and the informed consent forms were assessed at below a grade eight reading level, and informants could ask questions at any point, thus meeting the principles of voluntary, informed consent. Informants were not coerced or pressured in any way to participate, and were told that they could withdraw at any time, without fear of negative effects.

Confidentiality, Anonymity and Risk vs. Benefit

Because they were describing personal experiences, informants were vulnerable and confidentiality of

information was of prime importance. Safeguards to ensure confidentiality of information were outlined in the consent form and information letter. Only the researcher had access to the names and addresses of informants. Signed consent forms, tapes and transcripts were stored in locked cupboards and were accessible only by the researcher. If the abuse of a child had been disclosed or suspected, the researcher was bound by law to report it to the authorities; fortunately this was not necessary.

While the informants were not anonymous to the researcher, their identity and involvement in the study was not shared with others. Care was taken to maintain anonymity in the presentation of findings by not disclosing any personally identifying data. Pseudonyms were used for the informants and members of their families. Because of the small number of midwives practicing in Alberta, the risk of their identification was also considered. Individual midwives were given pseudonyms in the transcripts and their names were not used in the presented data.

There were no perceived risks to informants by participating in this study. These women were eager to discuss their pregnancy and birth experiences and safeguards to maintain their anonymity and confidentiality were addressed. While there were no tangible benefits to informants, the information shared may assist others who are seeking knowledge about midwifery care. In fact, many informants were very willing to share their experiences with other child-bearing women.

Ethical clearance for the study was obtained from the Faculty of Nursing Ethics Committee at the University of Alberta and from the institution overseeing the hospital-based midwifery demonstration project.

CHAPTER IV - FINDINGS

Introduction

The initial research question was why women chose midwives; however, the interview data also contained extensive descriptions of the care that the women received from their midwives and the process of choosing an alternative caregiver. Thus, the findings are presented to include the informants' reasons for choosing midwives, the process involved in their choice, and their perceptions of the care received from these midwives. The women were very eager to tell their birth stories to the researcher and these formed a significant part of the interview. Indeed, the initial question of the interviews became "Tell me about your last birth." Considerable information relating to the process of choice and the care received was revealed as women told their birth stories.

The Informants

The informants were twelve women who had experienced midwife-attended births between January and December of 1992. All informants chose midwifery care in Alberta prior to its formal implementation into the health care system. Six of the women gave birth at home and six in hospital. These twelve women were interviewed in person once, with follow-up telephone calls to two of them to clarify details during the transcribing of the interviews. One secondary informant was also interviewed to assist in validation of the findings.

Characteristics of the Informants

All of the informants except one were in stable relationships at the time of interviewing and most were married. The majority of the women were between 31 and 35 years of age, and most of their partners were slightly

older. Eight informants were not working outside of the home, one was a student, one was working part-time and two full-time. All of the informants had completed high school, most had received a college diploma and two had university degrees. Occupations varied from health care professionals to teachers to various business/clerical positions. All women were Canadian citizens. Two first-time mothers were interviewed and the remainder had experienced between one and five previous births.

The hospital and homebirth groups were similar in age, education and occupation, but there were two notable differences; both primigravidas were in the hospital group, and these two women were also the only ones currently working full-time outside of the home. Of the eight women not working outside of the home, five were from the homebirth group. Thus the two groups varied slightly in terms of previous birth experience and current employment status. While the purpose of the study is not to compare the informants who gave birth at home with those who had hospital births, it should be noted that the sample is relatively homogeneous with respect to demographic characteristics.

Six of the women gave birth at home, and six in hospital. Women in the homebirth group were cared for by midwives in each of the domiciliary midwife collectives in a major western city. In the hospital group, five women were part of a hospital-based midwifery demonstration project. Of the homebirth group, four informants had previous hospital birth experiences, while no one in the hospital group had ever given birth at home. Women had received maternity care from a variety of practitioners in the past, including midwives, general practitioners and obstetricians. While the focus of the study was the most recent midwife-attended birth, some informants had previously experienced midwifery care and these past

experiences were often related throughout the course of the interview.

One woman had a physician as the primary caregiver for her most recent pregnancy, but this was not clear until the interview was almost completed, and from her perspective the midwife was the most important caregiver. She had previously experienced two births in hospital attended by domiciliary midwives and had developed a close relationship with them. However, these midwives were no longer actively practicing and she had other circumstances that caused her to be under medical care. For this pregnancy and birth she had a general practitioner as her primary caregiver, with a midwife as support. Because of her previous experience with midwifery care and because her data are supported by others, her interview data were included in the analysis.

The twelve informants were given pseudonyms to protect their identity and verbatim quotes from their interviews will be assigned these pseudonyms. The twelve informants according to place of birth were:

HOME:		HOSPITAL:	
	Lisa		Amanda
	Elizabeth		Yolanda
	Opal		Karen
	Renee		Carrie
	Suzette		Mary
	Lucy		Tina

While each woman's and each family's circumstances and experiences were different and unique to them, common themes were identified through analysis and will be described in this chapter.

Initial Considerations for Choosing a Midwife

During their interviews, the informants were asked who or what initially influenced them in seeking a midwife. All of them described preliminary events, thoughts, or other influencing factors that triggered the thought of midwifery

care. The descriptions of influences on choice varied from woman to woman and will be discussed as a combination of internal and external influencing factors.

External Influencing Factors

External factors included various forms of literature, the media, others' birth experiences, and various community childbirth and women's groups. Many women described books that influenced their choice of caregiver. One woman read an account of a birth at home using the Leboyer method.

> So I tried to find that book and I read that book and then I was convinced...that's what convinced me really well. That's what it was, that book. (Suzette, line 588-591)

Other women describe the powerful influence of literature:

> And so I read his books and that really opened my eyes, because a lot of what he had said, I thought, 'That's right, that's what I see. Oh, that's not necessary.' It just gave me a whole new view and he explained why a lot of the interventions that were done with rupture of membranes, monitoring, episiotomies, lying on your back. All those things that were routine started to really make me think, 'Hey, it's not only episiotomies that I don't want, all these things I don't want.' (Opal, line 74-85)

> I read a book called Childbirth in Calgary or...Having Children in Calgary...and in it was the midwife collective....When I read about their objectives in terms of um...really assisting moms in their birth and being really low-key, I thought, 'This is what I want.' (Tina, line 64-70)

> And we had a chapter on alternate forms of medicine, I guess, and one of the things that was a topic in there was midwifery care. And at that point, it really, it struck a chord somehow. Something just piqued my interest. And at that point, I had thought if I was ever going to get pregnant, I'd want a midwife. (Yolanda, line 898-904)

Two informants mentioned the media exposure on midwifery as an influencing factor, especially during the trial of an Edmonton domiciliary midwife. "It must have

been because we had heard about the midwives in Alberta that it just triggered it." (Renee, line 371-2). Another described the media's influence:

> I had sort of heard little bits and pieces in the media...over the last couple of years. I remember one case in Red Deer where there was a midwife that had done a birth at home and that she was being charged with this, that, and the other thing. And I remember at the time being quite um...I guess, disappointed in our system and the fact that our care, the care system that we have in place wasn't meeting the kinds of needs that all the women have as far as giving birth or having babies. And um, that this was an option that people were criticizing without enough information. (Yolanda, line 927-942)

One woman had witnessed births during her professional training and stated,

> ..and the births I saw in hospitals I was quite horrified with, even though I was really young.... And um, I didn't think that's the way a baby should be welcomed into the world. (Karen, line 37-43)

Other women were influenced by friends' and family's personal experiences of childbirth. "And then my sister had a baby, um, delivered by Dr. X. And I was not impressed....she had every intervention under the sun." (Opal, line 105-109). Another said,

> ..some of my friends tell me about [their] birth and I think, 'Gee, I don't think you had to go like that. You know, you didn't have to end up being cut'. (Tina, line 623-6)

Two women had done prenatal teaching in the community and several others were involved in consumer groups such as ASAC (Association for Safe Alternatives in Childbirth), CAPSAC (Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth), and the La Leche League. Whether the women were influenced as a result of their membership in these groups, or whether they were part of these groups because of their existing interest in childbirth issues is not known.

Internal Influencing Factors

Internal factors are those considerations that originate within the woman, some of which may be her past personal experiences, and her beliefs about birth, health and the role of medical professionals. Some of the women had previous negative experiences with physicians and hospital birth. "We knew that we didn't want to go through another birth like we had with Devon. It was terrible" and "part of it was because it was too medically managed." (Renee, line 11-13 & 37-38). "And mostly it was the way I was treated in the hospital and the way doctors treat people and that's what I didn't like." (Lisa, line 215-217). Another woman had had a negative experience with an obstetrician/gynecologist during a previous pregnancy and "that was what definitely made me not go back to one.." (Amanda, line 903-4).

Other women had preconceived expectations about the medical care provided for normal pregnancy and birth. "I was really shocked to hear the doctor didn't come till you were about to deliver." (Tina, line 23-4) and "in logical thinking, it just seemed really stupid to go in there, with a strange nurse." (Tina, line 951-3). Another woman had similar misgivings about the physician, but perceived the nurse's presence as beneficial.

> I'd heard that the reputation of a lot of physicians and the care that you receive through a physician is that...you know, your chance are like 50/50 whether they're there basically to catch the baby and that you're going to have a nurse walk you through from beginning to end of the labour anyways. So I figure why shouldn't she be there for the delivery; she's likely to be there anyways, why have someone else be there to interfere? (Yolanda, line 792-800)

Not all women sought midwifery care as a direct result of previous negative experiences and some were essentially satisfied with their caregivers. "So I never really looked

too much into it 'cause I had my doctor and I was comfortable." (Mary, line 80-1). "I guess maybe because I was happy with my G.P." (Carrie, line 290-1). Another said "we didn't have the same bad hospital experiences a lot of the stories you hear about." (Lucy, line 898-9). For these women, it was not a previous negative experience that provided impetus to seek an alternative, but other circumstances, which will be described subsequently.

For some women, the choice of a midwife as caregiver corresponded with their own philosophy of birth and the value of a natural lifestyle. The choice for a birth outside of hospital was often integral to this philosophy. "For years, I've been into health foods, and natural...like we're organic farmers, too, it just sort of fits into the way I think." (Lisa, line 213-5).

> I was already with an attitude of...withdrawal from some technology. And I knew that in the hospital they would be giving me like that...I just didn't want that. I guess I'm like a 'granola' type. (Suzette, line 18-21)

> I've always seen birth as a very normal, natural part of life and nothing to get really whooped up over and so I guess that's part of it. (Elizabeth, line 58-60)

Two women supported the goals and philosophy of the hospital-based midwifery project, which influenced their choice to participate in it. One of them said,

> I knew that the midwifery programme at the Central hospital had just started....So I just thought any opportunity to use a midwife so I would. And I guess because the programme was new and I wanted to support it. (Carrie, line 14-18)

While it is obvious that the influencing factors for choosing a midwife are unique to the individual woman, each informant has been represented in the above descriptions regarding her own considerations. The main influences seemed to be various forms of literature, one's own and

other's birth experiences and one's underlying philosophy of birth.

The Influence of Location on Choice

Because the location of birth was a significant factor in choosing a caregiver, data on the influence of birth place are described separately from other influencing factors. Informants were asked whether the location of birth had an influence on their choice and if so, to further describe its influence. For some women, their initial consideration was related to an alternative place of birth rather than an alternative caregiver.

> I think I just always...someone told me before I was even married, someone told me that she had had a homebirth and I sort of went 'Oh! That sounds like a nice thing' and it was always in my mind. (Elizabeth, line 43-46)

Often the choice of a caregiver and the choice of birth place evolved together. Some women initially chose homebirths, and then realized that for the most part, it was midwives who attended homebirths. This reality is explicitly stated: "Because you can't have a homebirth without having a midwife." (Elizabeth, line 690-1). The synchronous nature of the choice of birth place and caregiver are described: "I think for me it was more...I wanted to be at home first. And then the two kind of went together." (Opal, line 880-2).

Some women who chose homebirths wanted to avoid the interventions, lack of control and other problems which they perceived to be present in the hospital system. Women talked about being able to control who attended their birth, "..that by having...a homebirth, you're in control of who is at your birth." (Opal, line 702-3), and generally being in control of their birth experience:

> Even when I first walked into the hospital, they wanted me to sign these consent forms. And I said I don't want to sign them, 'cause it just felt

> like I was losing control. (Elizabeth, line 478-480)

> ..you get to decide and you get to control... what's happening to you and things like that. And you can be with the people you want. (Suzette, line 747-9)

Other women described their interventive births experienced in hospital:

> ..and I ended up having things that I didn't want. The IV, I remember being really upset when they stuck that into my arm. I didn't want it. And then I wanted to not have my legs in the stirrups....But that's what he did. I swore that I'd never have another baby in hospital. (Lisa, line 250-258)

Another declared, "I'll try my darndest not to have to go to the hospital again." (Renee, line 448-9).

Some women chose homebirths because of the intimate, private environment of one's home. "It's a more peaceful experience and a calm setting than in the hospital where everything is so cold." (Suzette, line 573-4). Another valued "..just the comfort of my own home. I felt very comfortable at home. I could be myself." (Opal, line 872-4). Another woman stated that, "having a baby at home is advantageous for some things - the comfort, the familiar surroundings." (Lucy, line 1190-1). One woman appreciated the involvement of her other child at her homebirth.

> ..it was just a total peace the whole time. My sister-in-law was there with us and she would watch Devon... and he would come over and peek and see how things were doing....it was kind of neat that way. (Renee, line 338-343)

One woman described the lack of privacy in the hospital during her postpartum stay:

> And they kept coming in and the baby's doctor would come in and the obstetrician on duty had to come in and check on me. And a guy came in to change the shower head and they'd come in to take your blood...and someone to clean. I mean, there was somebody in there every half an hour. (Tina, line 439-444)

Some women considered having a homebirth, but had ambivalent feelings for varying reasons. One was living outside of the city and "..so a homebirth really didn't make a lot of sense in terms of emergency care." (Tina, line 57-8). Another lived in a very small home and had some reservations, but "..seeing that birth centres aren't available it [home] was still a better choice." (Lucy, line 885-6). One thought that she could "have the best of both worlds" (Carrie, line 401) by arriving at hospital, giving birth and going home again within twelve hours. She also described feeling comfortable at a particular hospital and therefore thought, "I would go with the midwives at that hospital." (Carrie, line 410-411).

Two women had not considered having a homebirth, but wanted to have their babies in a particular hospital setting. One had had her previous children there and was comfortable with the setting; the other chose to have her baby "with a midwife in a hospital in a birthing room." (Amanda, line 631). She explains her choice of the birthing room:

> [it was] not your regular labour and delivery room, which is so...impersonal. It's so sterile and white, all these lights staring at you, it's not very conducive to a happy feeling. And to being relaxed. (Amanda, line 636-640)

Location of birth was important to these women as well, but had a slightly different connotation; that is, a specific hospital setting as opposed to home or hospital.

The Process of Choice

Disenchantment with Conventional Birth

Many of the informants described some sort of process which involved questioning the conventional way of birth and realizing that they were searching for an alternative. For some, this process was conscious and systematic; for others

it was a vague realization that they were looking for something different.

> It was Lucy who stated that:
>
> I was really disenchanted with my doctor and I'd determined that....normal pregnancy didn't need to go through the medical system. (Lucy, line 130-134)

She also said "I really started questioning the need of doctors, hospitals, and anything like that to be involved in childbirth." (Lucy, line 58-60). Another woman described the process of how she "became dissatisfied with the conventional way of birth and how I was kind of looking for a midwife." (Opal, line 434-6). The significance of this cognitive process is described by Yolanda. "And it really just posed a lot of questions for me and I'm a...person that does a lot of thinking and so that was an important process for me." (Yolanda, line 947-950).

Other women were aware of what they did not want, but were not yet sure what they were searching for - "..but I wanted some kind of alternative." (Tina, line 52).

> I knew I was looking for something, but I didn't know exactly what I was looking for....All I knew was that I didn't want to go through the normal, you know... obstetrician. (Amanda, line 283-290)

All of the above quotations are from women who chose a midwife to attend them for their first birth experience. For some of them, their disenchantment with conventional birth began even before they became pregnant. Two of the women with previous negative birth experiences, Renee and Lisa, indicated that their own personal experiences were the source of their dissatisfaction with the status quo.

<u>Finding a Midwife</u>

Obviously, to find a midwife, one has to be aware that midwifery practices exist. A few women were searching for other birth alternatives, and found midwives somewhat serendipitously. One woman called her local hospital to ask about alternatives and was told about the midwifery

demonstration project, but "did not know that it [midwifery] existed." (Amanda, line 29). Another woman had "read about midwifery but [I] didn't think it was available in a way." (Mary, line 378-9). One said, "I didn't really know about midwives, I don't think. I just knew I didn't want to go to the hospital." (Lisa, line 16-17). Another was searching for someone to attend her at a homebirth, but "really didn't know much about midwives." (Elizabeth, line 700).

In contrast, some women were very aware of the presence of midwives, through their friends or professional affiliations.

> And I worked in the holistic health field, so I didn't have any problem finding them. In fact, they were patients of ours. So I just when we finally got pregnant, just contacted them right away. (Karen, line 44-47)

Others had a network of friends who had been cared for by midwives and simply obtained the phone number(s) when they became pregnant or needed more information. Another simply asked her general practitioner for a referral to the midwifery programme when she became pregnant.

For some women, however, the search was difficult and they encountered many obstacles and setbacks along the way.

> Well, we had gone to see one doctor or maybe two about you know...we wanted to see if a doctor would support us in trying to be more natural. I guess I was even thinking about having one in the hospital, but just if they would leave me alone. (Lisa, line 32-36)

This woman finally found a midwife when she was in her sixth month of pregnancy, and then chose to have a homebirth, too. Another woman, in her fifth month of pregnancy said:

> I went to my doctor and told him that I wanted a midwife. And he just hit the roof....So it was really hard to change doctors at that point. (Tina, line 72-75)

She later found a physician who was supportive of midwives.

Another woman "kept her ears and eyes open" prior to becoming pregnant, for any information about midwives and

homebirth. She heard the name of a physician who supported homebirth, phoned him and "it was that way that I found that 'Hurray!' there were midwives practicing here." (Opal, line 160-1). This woman's search was carried out before she even became pregnant. After finding out that there were midwives practicing, then she could relax because she "..didn't feel comfortable getting pregnant or being pregnant and then not really knowing exactly where to go." (Opal, line 187-9).

There was one woman who was referred to the hospital-based midwifery project because her physician was no longer practicing obstetrics and she thought:

> I'm definitely a low risk pregnancy, considering my last two, so I kind of felt that I didn't want to go an obstetrician/gynecologist. I just kind of thought it was a waste. (Mary, line 21-24)

It should be noted that in some cases, a different process for finding a midwife was used in subsequent pregnancies, depending on the options available. One of the midwifery collectives disbanded after having been in practice for some years, leaving a gap in midwifery services. This loss was especially significant for those women desiring midwives to attend homebirths. Therefore, women seeking midwives were limited to the options available at certain points in time, and in certain geographical areas.

<u>The Ongoing Nature of Choice</u>

All informants were asked if they had reconsidered their choice at any time. Many of the women described experiences of either doubt or confirmation regarding their choice of caregiver that occurred at different points during their pregnancies and births. Some also described mixed feelings related to the use of technology, various interventions, and the location of birth.

There were two women who had concerns about a particular midwife as their primary caregiver. One describes her initial meeting with one midwife as "Okay, um,

but she wasn't really acknowledging my fears at the time as to why I wanted a midwife." (Renee, line 28-9). She later met this midwife's partner and "just really liked her" and chose her as primary caregiver. Another woman chose a different primary midwife from the one who had attended her during her first birth experience, which had been an attempted homebirth ending in transfer to hospital. She "still wanted to go with a midwife", (Elizabeth, line 662) but said, "I also didn't want the same thing to happen and...not that I blame MIDWIFE'S NAME, but I just felt I needed to start fresh." (Elizabeth, line 445-7).

One of the women in the hospital midwifery programme assumed that she would have a primary caregiver in a "one-on-one relationship" instead of being cared for by a team of midwives. "So I thought initially, 'Oh, well, that's kind of not the way I wanted it' But...it didn't really matter." (Mary, line 552-5).

Some women described ambivalent feelings about different groups of midwives. "I don't know whether I would've gone...with the uh, lay midwives." (Carrie, line 1143). Referring to the choice of hospital-based midwives, one said:

> And I had mixed feelings about that, to be honest. 'Cause I didn't know them like I know my community midwives. (Karen, line 898-900).

One woman in the hospital midwifery group experienced a negative incident during her antenatal care, which caused her to doubt that the midwives would advocate for her if there were difficulties at the birth. After much discussion and an attempt at finding a different doctor, she "decided to stick with the midwife [sic] program even though I was really unhappy with that incident." (Tina, line 265-8).

Some women speculated about the knowledge and experience of the midwives. "I remember I wondered if she knew as much as doctors. Probably not." (Suzette, line

549). Another assumed she would be under the care of a midwife who had been practicing for some time, but was under a different midwife's care instead.

> ..but she was newer - she didn't have as much experience. So...it never changed my mind that I didn't want to have a midwife, but maybe for a moment between that phone call and my initial visit with her, that I thought 'Umm... I don't know, I think I might want someone with a bit more experience.' (Opal, line 809-816)

Some women described experiences that confirmed their choice or strengthened their convictions:

> ..in the meantime I went to the hospital with my friend who had a baby in hospital...it just convinced me again, the right choice I had made. (Suzette, line 110-116)

A woman who had chosen a midwife-attended homebirth went on a tour of the hospital that she had picked as backup in case of transfer. She was shocked at how hospital staff treated normal newborns, and said, "No one's going to treat my baby that way." (Opal, line 582). One of the reasons she gave for choosing a midwife was the sensitive treatment of the newborn.

Informants also described doubts related to their chosen birth place and the need for various interventions. While these data do not specifically describe the choice of caregiver, they are related to the ongoing nature of choice. One woman talked about her ongoing struggle with technology, which for her also included needing anyone to assist at her birth.

> It was the same thing with technology, putting this question again, requestioning this issue....Am I going to have this baby alone....Am I for technology or not for technology?....Do I need anybody? (Suzette, lines 464-477)

Another woman, whose friends were all having routine ultrasounds, wondered, "maybe I should have got one, but actually I was kind of glad I didn't." (Amanda, line 124-5).

Women also described their feelings of doubt or ambivalence about their chosen place of birth.

> I always worried about if something should go wrong, we're a long ways away and then you hear people say you can bleed to death in minutes and stuff. Yeah, that goes through your mind...But come right down to it when I was in labour I didn't think about it, or worry. (Lisa, line 285-290)

> ..there were times when I thought 'I'm going to be the only one of six of us who ends up in the hospital.'.... Of the six in our prenatal class. (Renee, line 287-9)

Another woman said, "..it is too bad that you have to do the hospital thing. I mean, I don't want to put it down at all." (Carrie, line 1298-1300).

These descriptions seem to indicate that choice is indeed an ongoing process. Many informants experienced either doubts or confirmation in their choice of a midwife as well as other birth choices. Choices were developed within the context of relationships, including the midwife-woman relationship.

Reactions of Others

During the informants' interviews, they were asked to describe the reactions of their partners, family, friends and anyone else significant. It was thought that other people's reactions, specifically their support for, or opposition towards the womens' choice of caregiver might have influenced them in some way. All of the women described the reactions of others and their influences, in varying depth. Within this category the descriptions the women gave of the reactions of male partners, family and friends, and health care professionals are presented.

Reactions of Male Partners

Reactions varied, but with one exception, all informants had the support of their male partners in their

choice of a midwife. One informant stated that it was essential to have the support of at least one other person, ideally your mate. Many husbands were present when the researcher came to the home for the interview and were very interested and vocal on the topic of midwifery care. A few men were disappointed that only the woman was being interviewed. In these instances the husband was eager to share his thoughts once the taped interview with his wife was completed.

Some of the men were strong supporters of midwives "from day one" and did not need prodding by or convincing from their partners. One informant described her husband's response as "He was with me all the way. He didn't have a problem, whatever way I wanted to go." (Mary, line 339-340) Some men were initially ambivalent about the care of a midwife and then became strong supporters after the birth experience. Tina said,

> ..he was really supportive of it. But probably if I hadn't wanted a midwife, he would've been just as supportive. The first time, after my first birth, oh, he thought that midwife was worth her weight in gold. (laughs) Like he said, 'We are having a midwife from now on.' (Tina, line 551-555)

Another woman said that after a midwife-attended homebirth, "he sort of went from so-so about homebirth to being radically active towards it." (Lucy, line 892-3). Some men received peer support through the prenatal classes offered by the midwives. Opal describes this process. "..some husbands were not at all for it. But through the prenatal classes and through talking to other men, or other couples, they really came around, full circle." (Opal, line 1003-6).

For most of the informants, it was the woman who initially considered choosing a midwife and then her partner agreed; some quickly, some after much deliberation. One woman describes the ongoing discussion with her husband

regarding her choice, first for a midwife, then for a homebirth:

> And he was open to having a midwife at our birth but then when I wanted a homebirth, it was I guess, you know, a funny look and..We talked a lot about it, he wasn't really difficult to persuade or to have him come over to...'Yes, let's have a homebirth.' He was all for having a midwife, definitely, but when we decided, when I decided that I would like to have the baby at home, I sat down one night and we were just sitting....and I said 'I want to have this baby at home.' And he said 'Oh.' (laughs) and just after again, more discussion between ourselves and with our midwife, it was decided that we'd have our baby at home. (Renee, line 171-184)

There was one informant who did not have the support of a partner at the time of her most recent birth. Her previous partner had been supportive of midwives, and was present and involved in her other births, but she went through this pregnancy alone. She described herself as a very strong and independent woman and this was her fourth midwife-attended homebirth, so perhaps support from a partner was not as crucial for this birth.

Reactions of Family and Friends

Some informants received positive support from family members and friends in their choice of a midwife. A few had friends who had also experienced midwifery care and one woman stated that "most of my friends are really, you know, kind of pro-birth" (Tina, line 541-2). Another was quite involved in the 'childbirth' community and her friends "just assumed that was what I would do." (Carrie, line 629). One said, "My mom was extremely supportive. She thought that was fantastic, she said if she would have been given the opportunity, she would have done it." (Yolanda, line 1183-5). Other family members were less enthusiastic, but respected the choice of a midwife. "We told Jean's parents. And they were fine. His mom's a public health nurse and I think she respected our decision." (Renee, line 219-221)

Some responses to the women's choice of caregiver were neutral or indifferent. This sort of reaction, while not strongly supportive, did not pose obstacles or interfere with their choice either.

> I told my sister. I told her we were going to have a midwife and then I told her we were going to have the baby at home and she's 'Oh.. okay.'....And I think I told a couple of my friends, too. And they said 'Oh' - same sort of response - 'if that's what you want to do.' (Renee, line 207-215)

> My older brother didn't say anything one way or the other. He wasn't against it, but he just didn't really seem to have an opinion, or if he did, he didn't let me know about it. (Lucy, line 925-8)

For one woman, this lack of concern and opposition was beneficial. For Lisa's third midwife-attended birth,

> ..no one really, it was like everyone sort of let us alone then. No one ever bothered us, or said, 'No, you shouldn't do it this time or..' They just let us alone. So....I felt better that time. (Lisa, line 173-176)

Disapproval by family members was directed towards the choice of birth place more so than the choice of caregiver and therefore, was discussed primarily by the women choosing midwife-attended homebirths. One woman said, "I think that they were probably in favour of the midwife but they were a bit afraid of the homebirth part. In case of emergency, whatever.." (Opal, line 388-391). Others commented that:

> My husband's family, well they got a little vocal about it. 'Well, no, you should be doing this in the hospital first and see how it goes and what if things go wrong?' (Lucy, line 929-931)

> ..like I said before, I don't think we'd have enough support from our families to do a homebirth in terms of our outside family, you know, grandparents and things like that. (Tina, line 821-824)

Opal considered having her son present at her second birth if someone would come and watch him, but "neither one

of us had friends close enough that were sort of supportive...with midwifery and homebirths." (Opal, line 297-9). Other women expressed that they "didn't feel a lot of support" (Elizabeth, line 639) and "would have liked more support from people" (Lisa, line 145).

Reactions of Health Care Professionals

Women who participated in the in-hospital demonstration midwifery project required a referral from a physician to the programme. Several of these women found their physicians to be supportive of the programme and very open to alternatives in childbirth. Mary mentioned the programme to her general practitioner, and "he had sent some of his patients already to the midwife programme, so he said he thought that was a great idea." (Mary, line 25-28). Another found that her doctor was "very supportive" and said "you can do whatever you choose." (Yolanda, line 32,33). Tina's doctor initiated the referral by saying "You know what, there's a midwife programme at Hospital X. ....I bet you'd be interested." (Tina, line 113-5). Karen stated that her doctor:

> didn't mind the midwives and when I told her I was contemplating a homebirth, she thought I was nuts, but said she'd attend me in whatever manner I wanted her to. (Karen, line 230-3)

Other women found no support from health care professionals when seeking alternatives. When discussing a more 'natural' hospital birth with one physician, Lisa found that:

> In fact, one doctor was quite rude and walked out of the office on us. He wouldn't even shake our hands or anything. He just left.. (Lisa, line 42-44)

One informant describes the reaction she received while speaking with one physician about different birth alternatives. "So of course I told him I'd been planning a homebirth and stuff, and he wasn't too amused about that

either." (Lucy, line 293-4). Yolanda describes an interaction with a physician while she was seeking care for a problem unrelated to her pregnancy:

> They asked me how pregnant I was, and I said, 'Well, I'm at 42 weeks.' And they said, 'What, they're not inducing you?' And I said, 'No, I'm with the midwifery programme.' She goes, 'Ohh.. well, are you sure that's not harming your baby or anything like that?' and I said, 'No, every indication is that my baby is fine and that I'm fine and that we're going to wait until..we actually have to make the decision to induce me.' And uh, I think the doctor was a little shocked. (Yolanda, line 1066-1074)

The support (or lack of it) from professionals could be described as instrumental support for a woman's choice, ie. initiating referral or providing backup care, while the theme of support from partners, family and friends might be more emotional or social in nature. Sources and types of social support will be discussed further in the next chapter.

Going against the Majority

This category contains descriptions of how the women felt in response to others' reactions and how they coped with perceived minimal support for their choices. Many informants had to contend with others' misperceptions of midwives and their care, while defending their choice. Some of their responses included feeling alone, guarding their choice from loved ones, and being bothered or not bothered/influenced by others' opinions and expectations. A few women became role models or 'trendsetters' for others in choosing alternatives related to childbirth.

Because midwifery has only recently been recognized as a legitimate profession here in Alberta, many people had false assumptions about midwives and their practice. Some conjured up the image of the 'granny' midwife of their grandmother's era or automatically assumed that having a midwife meant having a homebirth. There was a general lack

of awareness of midwives and the informants needed to enlighten many people about the current practice of midwifery prior to gaining their support.

One informant who had a midwife-attended hospital birth described people's responses this way: "Initially people would say 'You're having a midwife? You're going to have the baby at home?' and then I'd explain to them and then they were... supportive." (Mary, line 335-338) Another describes the same sort of reaction: "I had a few friends kind of look at me cross-eyed and think, 'Are you going to have a baby at home?' Kind of shocked, eh." (Yolanda, line 1202-1204) One woman's mother:

> [she] was under the impression, too, that you know, the midwives you think of are the kind that your mother had or, actually her mother had at home, you know. Like the neighbour comes over and that's it. But uh, they didn't realize they were fully trained and... professionals, so. (Amanda, line 319-325)

One woman describes the lack of understanding quite candidly:

> A lot of people didn't even realize...this project was happening or that midwives could deliver. They thought, 'Oh, it was still against the law.' So a lot of education went on. (Carrie, line 654-7)

Several women described feeling alone in their choice and one stated "It's hard sometimes to go against the majority. Very hard." (Suzette, line 796). Another said, "You kind of feel a little bit...odd, you know, people kind of single you out sometimes" (Lisa, line 75-6). One said her friends thought she was "a little strange" and wondered, "Am I the only one who thinks that this is something natural?" (Amanda, lines 330 & 356). This same woman, while feeling somewhat alone, also felt "special" and that she was in "this select group that's going to get better care than anybody." (Amanda, line 413-418).

The woman whose partner had left her during the pregnancy said, "so it was pretty much all by myself already. So it was just continuing that cycle." (Suzette, line 488-9). In conversation following the taped interview she described herself as strong and not being overly concerned about society's expectations. When asked whether other people's opinions had a big influence on her choice, one woman replied:

> No. No... I figure my, my decision was based on a lot more knowledge than their opinion was, so therefore their opinion didn't really mean an awful lot to me. (Lucy, line 938-942)

Another woman, who was the first in her peer group to have a baby and to receive midwifery care, said, "I sort of started a trend and uh, so that was kind of neat. And I tried to be a resource for them." (Elizabeth, line 635-6). Lisa was also the first woman in her family to choose a midwife, but others made the same choice after hearing about her experiences. Other informants said that they definitely helped to "spread the word" about midwifery care.

Four of the women who chose midwife-attended homebirths described the idea of being selective with whom they shared their choice, by telling the right people and not telling the wrong ones. One thought that she didn't receive any negative responses because, "I guess I told the right people maybe." (Renee, line 237). She did not tell her mother of her plans prior to the birth as "I just thought she would have worried so much and she would have." (Renee, line 206-7). Another did not tell her mother-in-law for similar reasons:

> We talked about it, but we didn't even actually tell her when I went into labour, we didn't tell her until after he was born. (laughs) Because she just gets too stressed out about it. (Elizabeth, line 617-620)

Because of previous negative responses, one couple was quite evasive about their choice, almost as a protective mechanism.

> the first time around, I guess we talked a lot about it to people around, you know, tried to get them to understand and the second go-round we figured we wouldn't say much. Keep it to ourselves....We just decided it was best if people didn't know too much. (Lisa, line 137-144)

One woman did not share her choice with health care professionals "because I already knew what they thought about midwifery care." (Opal, line 318-9). Presumably these thoughts were not favourable.

Shared Belief in Natural Childbirth

Many of the informants described childbirth as normal, natural and physiological, which is best achieved when allowed to proceed without intervention. They supported the philosophy of choosing less intervention in favour of a more natural approach to birth. Several women stated a belief in "allowing nature to take its course". (Amanda, line 138; Opal, line 457; Suzette, line 650; Yolanda, line 299). Another described herself as "a non-interventionist." (Tina, line 295).

Furthermore, it was known that midwives shared these beliefs and held a common philosophy regarding childbirth. For her birth, one woman wanted "someone with...more of a natural childbirth background. And who better than a midwife?" (Renee, line 407-8).

> ..they don't lean on medications to relieve the pain of childbirth. They know that pain and childbirth go together, and they encourage you to work with that, ...moaning and groaning and walking, whatever.. (Renee, line 299-302)

Another stated, "Birth is physiological, not pathogenic. And that was their theory...you don't have to worry unless there's something to worry about." (Carrie, line 1053-6).

"They treated you as...birth is something natural, it's something wonderful...." (Amanda, line 73-4).

Two informants described how the midwives' treatment of a newborn baby and respect for the mother-baby relationship were part of their reasons for choosing midwifery care. "I think it's for the baby. Yeah, because when I see a birth which I don't agree [with], I feel for the baby..." and "The real reason is for the baby." (Suzette, lines 725-6 & 732). Another said,

> I feel that the midwives would just let me hold my baby however long and just even the way, when they examine the baby, I could hold the baby against me and..it just was so much more natural, like that mother not wanting to just leave her baby.. (Opal, line 610-615)

As part of their belief in birth as natural, the midwives supported selective and judicious application of technology:

> Their belief was that if you didn't need it, don't do it. Like don't do it just 'cause the technology is there.. (Amanda, line 128-130)

Amanda was referring to routine ultrasounds, internal exams and drugs during labour. Other interventions that women described as being undesirable were episiotomies, enemas, intravenous lines, and stirrups/supine position for delivery.

Instead of these kinds of interventions, midwives used "visualization, relaxation, massage. That kind of thing." (Tina, line 417). Some midwives were also open to herbal and homeopathic treatments which were used by one woman during her pregnancy. During labour women were encouraged to walk around:

> I kept walking around. I was making soup up until an hour before I had him and then sat in this chair (birthing stool) and that was it! (Lisa, line 441-3)

or to assume a more natural position for delivery:

> ..I delivered her on all fours and...it was very natural and it...was easier on her I'm sure, and easier on me. (Mary, line 348-351)

The essence of this shared philosophy between midwives and the women they care for is captured by Carrie's statements: "I really believe in...everything that a midwife stands for basically." and "When I went in there and we talked, it seemed very comfortable. Everyone [was on] the same wavelength." (lines 29-30 & 1205-6).

The Midwife-Woman Relationship

The majority of the data collected during interviews pertained to the relationship between caregiver and client. Women described this relationship in great detail and it is indeed a complex and deeply meaningful phenomenon. It may be somewhat artificial to describe facets of this relationship separately because the data are very interwoven and overlapping. However, data about this relationship will be organized into descriptions of the attributes of the midwife, the actions of the midwife, and the nature of the midwife-woman relationship. Interspersed in these categories will be the womens' comments on their part in this mutual relationship.

Attributes of the Midwife

The primary attributes of the midwife, or adjectives describing her were female, knowledgable and known. Perhaps including one's gender as a personal attribute is not quite 'politically correct'; however, the fact that the midwives were female was important to many of the informants.

Female Empathy

Some women stated simply that one of the reasons for choosing midwives was that they were female caregivers. "It was nice talking to women. My doctor's a man...it was a good thing that way." (Mary, line 516-7). Others talked

about the shared experience of giving birth and mothering children as beneficial, perhaps even necessary.

> I feel much better with a woman to have a child than with a man because like the first doctor I went to see told me 'Listen I [have] attended 10,000 births. I know what it is.' I thought, 'You don't know what it is. You know, like you never had a baby. How can you say you know what it is?' (Suzette, line 521-5)

Another said:

> There's a lot of physicians that may or may not have ever had a child...and I know that's not necessarily a really strong argument, but to me it was important to know that. (Yolanda, line 857-9)

This understanding of a mother's thoughts was described by one woman who had experienced a very difficult birth:

> ..she must have known what a woman would be looking for in this state, and she finally said, 'Karen, your baby's on your chest' and she took my hand up and that's what I was looking for.. (Karen, line 1312-4)

Other descriptions included 'empathy' and 'compassion' and "she knew, as a woman and a mother, what I needed to hear.." (Karen, line 1444). The attribute of shared female experience, especially motherhood, and the accompanying empathy is beautifully described by Renee:

> I felt a compassion and a warmth...there was a tenderness in the way they would palpate the abdomen...I could feel a love from them, too. Yeah, I guess a compassion would evolve from them having their own children and going through a lot of the similar things, too. (line 307-312)

These quotations emphasize the value of the midwives' personal experience with birth and mothering as more important than the simple fact that they were female.

Knowledgeable

Informants described their midwives as very knowledgeable, expert, and specialized in normal pregnancy and birth. Other remarks/descriptions included 'trained', 'professionals', 'experienced', 'well-educated' and 'a

wealth of information'. One said "That is their focus - you know, just having babies." (Renee, line 295). One woman described the 'specialized care' of a midwife as:

> ..caring for the woman and the child...early on in pregnancy and follow[ing] them right through. And even after...you have the baby, for me, that's specialized because that's all they do....That to me, means that they have got tons more experience than a lot of other people. (Yolanda, line 844-852)

She also stated that their specialization "indicated a higher level of care." (Yolanda, line 865). Another said that "I felt really confident in her care, like more so than the doctors. Because she's specialized in that...." (Lisa, line 535-6).

As noted above, the midwives' area of expertise was normal childbirth, but their knowledge base was often in relation to non-technological and alternative methods. They used many 'tricks of the trade' and suggested various ways for turning breech babies, pain relief methods during labour, herbal remedies, etc.

> ..the midwives gave us all kinds of suggestions on how we could maybe turn the baby by ourselves...So I was doing the old waddling in the air on the knees trick... (Yolanda, line 124-6).

> And I had this old ironing board at home that I would prop up against the couch...and be lying upside down on that....and [MIDWIFE'S NAME] would work on it 'cause she'd had a fair amount of success with external version.. (Lucy, line 653-661).

> ..they were always saying that there's different ways instead of giving you drugs...there's the hot shower and um...laughing gas....Oh, there's a whole bunch of techniques that we have.. (Amanda, line 673-681).

> And then I dropped in to the midwives clinic one day... and mentioned the problem and [MIDWIFE'S NAME] suggested an herb I could try and that helped right away. (Lucy, line 434-7).

Another woman described how the midwife "knew exactly what I was doing" when she arrived on the scene:

> And I was walking the pain off and the labour off. But it wasn't the right thing to do 'cause she immediately saw me and she said, 'Wait a second. You're running these halls!.... You need to settle down, relax, maybe have a shower, and let's get things started.' Well, almost immediately... I started going through some serious labour pains. (Tina, line 979-986)

The effectiveness of the midwives' knowledge regarding common complaints of pregnancy is described by another woman, "..every time I went in with a little quirk or a creak or an ache, she would say, 'Well, try this.' And I would try it and it worked." (Renee, line 263-5).

Two women described a midwife as having intuition or a sense in certain situations. This special kind of knowledge is shown in the following exemplars:

> But the whole thing is, with the first one, [MIDWIFE'S NAME] knew intuitively that I had to be in the hospital....And they knew things ahead of time, they knew when things were happening. (Karen, line 1359-1363)

> She [the midwife] said, 'With some women who come in, you have a sense that this is going to be difficult.... I had a real sense with you that this was going to be a hard one.' (Tina, line 671-3)

Some women also commented on the midwives' knowledge and skill in critical situations. One woman had a baby who was initially slow to respond and stated about the midwife's care:

> ..but now I know that they don't take chances. If they see something go[ing] wrong, they will either give you a choice or if they think there's no choice to be made, they'll tell you, 'Well, we have to go to the hospital.' (Suzette, line 564-9)

Another woman had a baby who needed to be transferred to medical care and was satisfied with the midwife's competent

care during that time. One woman described her confidence in the midwives' care if a complication arose:

> ..and I knew that if, God forbid, something went wrong that they would know when to call someone if I needed more intrusive measures involved in my delivery. (Yolanda, line 1057-9)

Known Presence

The final attribute of the midwife was that she was known to the woman; she was a familiar presence. This attribute is more difficult to delineate, but involves the ideas of intimacy, and the women's comfort with and knowledge of the midwives. This familiar and comfortable relationship developed over time and will be further described in the category on continuity of care. In this section only the informants' data on the midwife as a known entity will be described, and not the data on the woman being known to the midwife.

Several women described the intimacy and sacredness of birth. Some felt that such a momentous event should be shared with familiar people, not strangers:

> I just did not feel comfortable about going in and having labour with a complete stranger there... who doesn't know me, doesn't know my pain threshold and knows nothing about me....I just thought, 'This doesn't make sense. This is the biggest moment of our life'....and I didn't feel it was right to share it with people who don't know anything about me. (Tina, line 498-511)

> One of the most important parts for me was getting a chance to meet all the midwives and to know them all by name. And so that I wouldn't feel like there was a stranger present when I actually had my baby. (Yolanda, line 53-57)

Elizabeth decided that she "had too many support people" at her first birth, some of whom did not truly support homebirth or understand the whole process. (Elizabeth, line 520-27). She felt this lack of quality support and intimacy was detrimental. Another woman stated, "I don't like seeing a lot of people, particularly a lot of

strangers...cause it's a kind of vulnerable time of your life." (Lucy, line 988-990).

Some women also commented on the intimate nature of vaginal exams and stated that they preferred to know the caregiver who was performing them, "I have to feel comfortable with the person who I'm going to be seeing a lot and them doing...fairly intimate things." (Amanda, line 31-313).

Many women described the comfort and ease they felt with the midwives over time. "I met them [the midwives] and I felt completely at ease....and so as we continued throughout the months, you get to know everybody." (Mary, line 106-9). This same woman described arriving at the hospital, and "then the nurse-midwife was there, so right away you see someone you know." (Mary, line 189-190). Many expressed the need to feel "comfortable with my caregiver" and one said about her midwife, simply, "I know her and I really like her." (Suzette, line 787). This known and comfortable presence of the midwife is an important attribute of the caregiver, and will also be discussed as part of the midwife-woman relationship.

Actions of the Midwife

Informants described several distinct actions by the midwives that were viewed as valuable in the midwife-woman relationship. These actions were identified as being there, supporting, spending time, sharing information and advocating. The informants' perceptions of each of these actions will be presented below.

Being There

Several women described the midwives as 'being there for me'. 'Being there' could refer either to the midwife's actual presence or the assurance that the midwife would be there for the birth and for any difficulties along the way. The quiet attendance of the midwives was described as "They didn't do [much] really that I remember other than just

being there." (Suzette, line 152). Another woman said about her midwives,

> they're not afraid to cry with you or touch you or..be there. I think that was a major thing. (Lucy, line 330-332)

One woman repeated throughout her interview that, "I knew that they would be there when everything happened" and "they were just with you anytime you wanted to call them, they were there." (Amanda, lines 80 & 438-9). The word midwife means 'with woman' in old English. One woman praised her midwife by saying, "She was truly the midwife, she was there for me." (Karen, line 957). While simple physical presence may not truly constitute an action by the midwife, these women perceived 'being there' as meaningful.

Support

Many women stated that their midwife acted as a support for them or gave them support. The word support was used in several different ways, and could refer to the ideas of encouragement, help or assistance, agreement with certain beliefs, and physical support, among others. Some descriptions of the midwives' actions and words during labour follow:

> And all the time, [MIDWIFE'S NAME] was giving me massages and telling me what a wonderful person I was and stuff, which was really nice. (Karen, line 948-950)

> ..one of the midwives stayed all through beside me and ...just massaging me, which helped me a lot...and they were just quiet, they would tell me things to support me. (Suzette, line 148-151)

> We were inside the shower...and she had the door open and she was massaging my back while Dave was squirting me with the water and just them throwing encouragement at me to continue... (Yolanda, line 395-398)

> ..when it was dragging on so long...she just really was talking to us, telling us everything

> was going to be fine and 'You can do it' and 'keep trying' and.. (Lisa, line 401-404)

Other women described wanting or receiving help from the midwives. "Because I did feel that a midwife would help so that I wouldn't have as many interventions and she would be there as my support." (Opal, line 861-3). Referring to her pregnancy, one woman said, "I didn't know that much about it and I'd sort of wanted help along the way." (Lucy, line 98-99). A woman whose infant was hospitalized said that her midwife "came to see us and was really helpful...she even had us over for supper one night." (Lisa, line 481-3). A woman having problems breast-feeding described how her midwife supported her:

> ..she kind of helped me through...she said, 'You tried everything possible - you went for all the help you could.' And she did nice little things like [writing] notes and saying 'Babies can live without breast milk but they can't live without love and that house has a lot of it.' (Karen, line 1435-1440)

Women received support from midwives for practices like breast-feeding and beliefs like freedom in birth.

> ..I was really committed to breast-feeding and I knew that I'd need some support and the midwives are very good at giving a lot of support for that. (Elizabeth, line 31-34)

> ..[midwives] support other women to give women back the freedom that I think we need in the birth place....to have their best interests respected and I really think that is something that happens with midwives. (Carrie, line 1177-1181)

Other general comments included: "....midwives are wonderful. Just in terms of helping you feel supported through your birth.." (Tina, line 1237-9) and "I knew that we wanted somebody with us to help support us in the birth." (Renee, line 368). The action/perception of support was described by almost every informant, in one way or another.

Spending Time

Midwives spent time with their clients. All of the informants commented about time, in reference to the availability and the patience of the midwives, or the length of appointments and visits with them. Many made comparisons between the amount of time spent with midwives and the time spent with other caregivers. More time was often associated with better care.

Several women stated that the midwives were available, they had time to talk, and they were quick to respond to phone calls. "I could call her up anytime and she was there.." (Renee, line 266). Another said, "they'd always call you back when you called them....if you got the answering machine, they were always quick to call you." (Amanda, line 961-968). The 24-hour-a-day coverage was described, too. "It was really good that they could come any time during the day or during the night to assist your labour and to stay as long as it was needed." (Suzette, line 844-6).

Along with the idea of availability, the women described an openness and did not perceive that they were being seen as a nuisance or bother by the midwives:

> ..right from the time you first start going, she's got time to talk to you if you have questions. I always felt that if I really was worried that I could phone her and not feel that I would be imposing. (Lisa, line 229-232)

> ..definitely the time was there for you and....it didn't matter how much time you needed. They gave it to you if you needed it. (Carrie, line 300-303)

Many of the informants commented on the length of the appointments with their midwives, especially the first one. This time was perceived as valuable in developing a relationship. "I remember my first appointment ever with a midwife probably took an hour and a half." (Lucy, line 1269-70). Others stated that:

> I really like the kind of care that I received from them, just because it wasn't your typical fifteen minute appointment...the first one was like an hour and a half long. (Yolanda, line 57-60)

> ..she was going to take her time and she was going to know me....twenty minute visits are not enough time to really know what I'm like. (Tina, line 1207-1209)

> But I found just seeing a midwife for my prenatal care, I mean I got 'A-1' care....my visits with my midwife were a half an hour. (Opal, line 337-341)

Informants also described the length of time that midwives spent with them overall. "But the midwife came quite early and she stayed with me all day." (Suzette, line 76). Another stated, "they stayed for quite awhile. They stayed the whole night, and made sure everything was okay before they left." (Lisa, line 122-4). One woman outlined the time taken for her entire birth experience:

> ..the time that they spend with you, just for the birth. And just for afterwards and then you have to figure all the time they spend with you and the prenatal classes.. (Elizabeth, line 842-6)

Some women talked about the patience of the midwives and that they did not feel "pressured by the clock." (Opal, line 468). This feeling was especially important in labour. "..it's not being done for the sake of somebody's convenience or...you're not following a predestined clock to try and get this baby out." (Lucy, line 1018-20). In the following quote, the importance of patience to this woman is illustrated:

> The biggest thing that I remember is just how patient they are. They're not in a hurry to rush things..and they don't make you feel like you're costing them time or whatever because you're not having this baby at a certain time. You can just have it when you're ready and...that's just fine...That was really important to me. (Lisa, line 394-401)

Comparisons were made in regard to the time spent with clients by midwives and physicians. One comparison was that "...they [physicians] don't tend, comparing it with the homebirth later, they don't spend time with you." (Lucy, line 389-391). Another woman said, "they [midwives] would take their time. Not like in a doctor's office, you end up sitting there waiting 'cause he's lined up so many patients." (Amanda, line 423-5). The midwife's action of spending time with her clients was noted by many informants, and was perceived as positive and beneficial.

Information Sharing

Another action performed by the midwife was to share information with the woman for whom she was caring. Informants commented on the content of the information communicated, and also the manner in which this communication took place. Often information was relayed as a number of suggestions as opposed to specific instructions. Midwives also encouraged women and their partners to read childbirth literature in order to make their own informed decisions. The act of sharing information was noted more by some informants than others, especially Yolanda, who described herself as needing to be very informed and involved in decisions regarding her care.

The women used phrases like 'work through issues', 'talk about my concerns', 'ask any questions', and 'explaining things' to describe the information shared by their midwives. The content of information seemed to be directed by the individual woman. "Like if I would say, 'Well, I don't understand this' or 'What's happening now?' they would sit and they would tell you about it." (Amanda, line 1003-5). The midwives could direct a woman to further information because "they know what you know. If you're lacking in knowledge somewhere they can point you in the right direction." (Lucy, line 1007-8). One woman:

> ...relied on the midwives to give me honest answers to my questions....I would say to them, give me some numbers here, tell me. If I leave this baby breech, what are the chances it's going to turn on it's own? If I have this baby turned, what are the chances that it's going to turn back anyways?....So I tended to get a lot of information and make a decision which I felt they supported me in. (Yolanda, line 1099-1108)

Midwives gave women information about what was happening with their body and their baby at various points in pregnancy. One first-time mother commented on how the midwives addressed her informational needs: "...just telling you what's going on with you and your body and what's going on with the baby..." (Amanda, line 938-940). Yolanda described the pro-active nature of information sharing by the midwives:

> ...they answered a lot of questions that probably had been buzzing in my mind for many, many weeks but I hadn't had a chance to sit down and write them out. And so if I had gone into a doctor's office I would never have gotten those questions answered. (Yolanda, line 823-8)

One informant commented on the midwives' prenatal classes and found that "...it was a lot more information. It was very informal, and we talked, we shared and I really enjoyed that." (Opal, line 1021-3).

Some women described the manner in which the midwives shared information, which seemed to be via suggestions and by encouraging women to learn and to make decisions themselves. One woman and her midwife "put our heads together" to solve a problem. (Karen, line 1051). Another woman described how the midwives taught her to test her own urine at her prenatal visits and commented, "This way you felt like you were actually seeing what your body was doing and you were finding out how much you weighed and stuff." (Tina, line 1173-5). Yolanda appreciated the openness and equal footing she perceived in her interactions with her midwives:

> I didn't feel like there was any hiding. I didn't feel like they were pretending that they had this knowledge that only God-given people are given...and that I wasn't knowledgeable enough...to be able to make a decision on my own as opposed to having somebody else make it for me. (Yolanda, line 1241-1247)

Advocacy

One of the roles of the midwife was to act as an advocate for her client. Some women recognized that it may be difficult to fight for their rights/choices in a hospital setting and wanted to take 'someone else' with them to act as a mediator. The need for an advocate was especially great when the woman was vulnerable and less able to speak for herself. Some vulnerable times described by the informants included the transition phase of labour and the time of delivery:

> Our initial feeling was we wanted an advocate - someone with more knowledge and someone who could help us through when you get to that point where you just can't think, for someone else to say, 'Okay, Renee, now...' (Renee, line 55-58)

> And I don't want to have to fight during a contraction and say, 'No, don't do this to me, just give me more time.' You don't have the energy to do that. (Opal, line 664-7)

Another woman described the point in transition when "you need somebody there to...to be strong and say, 'Do this, do that.'" (Amanda, line 750-2). Elizabeth was very concerned about having an episiotomy in the hospital and asked the midwives to act as her advocates with the delivery physician. One woman described her midwife's actions when her baby was separated from her just after birth. "[MIDWIFE'S NAME] just said, 'Mom wants the baby!' and they handed her to me." (Karen, line 1189-90). One woman and her baby needed to be transferred to medical care and she described the midwife's response to the hospital staff who were focusing only on the newborn:

> [MIDWIFE'S NAME] got quite upset and said, 'There's a mother here that needs care, too.' Right away she was...so then the nurses started you know, looking more after both of us. Once we got there, then she made sure everything was okay.... (Lisa, line 468-471)

Other comments about the role and action of midwives as advocates include: "She sort of intervened and took care of everything else." (Carrie, line 185) and "When it comes right down to it, you need somebody who's really going to be on your side...and really, truly believe what you say." (Tina, line 1284-5).

Some women described their husband's feelings of relief regarding the midwife's presence during their births, "...there was somebody there and it wasn't all on his shoulders" (Tina, line 570). "He didn't really have the pressure on him like he had with the other two." (Carrie, line 169-70). Another described her husband's response after sharing in a midwife-attended birth: "And now he's a very strong advocate of midwives." (Renee, line 419). He appreciated the midwives' action of advocacy and now advocates for them.

One woman chose a midwife because she really wanted "someone who would be an advocate for me", but after two negative prenatal experiences, stated, "...it was really uncomfortable for the midwives because they wouldn't advocate for me." (Tina, line 228-9). She later commented that this may have been related to the midwives' role within the institution and program, and not to their lack of trying.

Some women had needed to fight in the past to have their voices heard during their birth experience. One woman said, "I was happy enough with mine [my experience] only, only because I was very assertive." (Carrie, line 1301). Elizabeth talked about "putting pressure" on physicians and phoning them at home. Karen had "refused" an induction and

other interventions, but as one said, "there's only so much you can do." (Carrie, line 950). Some of the informants chose midwives in order to avoid the need to fight - either to attend them at home, thereby avoiding the possibility of interference, or to go with them into the hospital system where they could act as a 'buffer' and a mediator.

Some women stated that one of the benefits of a homebirth was not needing to fight. "And especially now in hindsight, I think I'm glad I didn't have to fight for my rights...during the time of labour and delivery." (Opal, line 668-671). "I guess I felt at peace with this birth. I think...having a midwife and then having the baby at home lifted a lot of that off my shoulders." (Renee, line 279-82).

Carrie had a midwife-attended hospital birth and repeatedly described the idea of not needing to fight or to "battle my way". "You didn't feel like you were going out on a limb...." (line 1210) and "I felt like I didn't have to fight for anything, that everything was there." (line 546-7). She compared her midwife-attended birth with a previous one:

> I didn't feel like I had, you know, with my last birth, I had a lot of things that I wanted to make sure were done. And so I went in there...being very assertive and...with this one, I felt like I didn't need to have my guard up. (Carrie, line 98-106)

The action of the midwife as an advocate was described by many informants as being a very significant part of their experience and this action of advocacy replaced the women's need to fight. Midwives were also expected to act in an advocacy role by their clients and for some women, this was a prime reason for choosing a midwife.

<u>The Nature of the Midwife-Woman Relationship</u>

Having recounted descriptions of the attributes and actions of the midwife, the relationship itself between the

midwife and her client will now be addressed. The data on the relationship are the heart of the research and provide many answers to the basic question of "Why do women choose midwives?" Data on this relationship were broad and multi-faceted, and were provided in great depth by all of the informants. The importance of the relationship was demonstrated by a woman who initially chose a homebirth, and consequently a midwife.

> ...and as I got to know [MIDWIFE'S NAME], I started to realize that it's not just about having homebirths. But it's about having a midwife as well. (Elizabeth, line 25-27)

This unique relationship is characterized as family-oriented, wholistic, woman-centred, ongoing, and one of trust and deep commitment. Each of these themes will be described in turn.

Family-Oriented

The midwife-woman relationship was characterized by its focus on the woman's family and their inclusion in the experience of birth. Women described how the midwife included their husbands, children, and other family members in their care throughout the entire experience. One woman described this family-oriented care, "when the midwife came for the home visits after...it was whole family kind of thing." (Opal, line 769-771). One woman described her birth experience as being "focused all around the family and supporting each other and everything...." (Amanda, line 470-1). She also said that "they would be talking to both of us, like we were both part of the whole process and not...him just at the end." (Amanda, line 454-6).

Several women described how their husbands were made to feel part of the experience and that the men appreciated this opportunity and the midwives' care:

> ..Dave felt like he was being a part of it and being included. It wasn't just simply a woman having a baby and he was just the father. So he really liked that.... (Yolanda, line 79-82).

> But the midwife was there for him, too, not just for me. Like...even just rubbing his back and saying, 'It's going to be okay. Everything is going fine.' And to him, that was just the greatest thing. (Tina, line 566-569)

One woman commented that the experience brought her and her husband closer together. "I think it was a very growing experience for me and my husband. In that we had to do a lot of reading and a lot of sharing together." (Opal, line 897-900).

The family-oriented care extended to a woman's other children, too, and their children's involvement was described by several women. Lisa commented on the inclusion of her children during her prenatal visits, "They [midwives] are really helpful that way with the kids, too. They try and explain stuff so they're not confused or worried." (line 330-2) and "it makes them feel a part of what's going on, too, which is important They don't feel left out." (line 342-4). Another said, "I really enjoyed going to the midwives and their visits....Devon used to come with us and play and feel the baby move...." (Renee, line 304-306).

Some women wanted their children to be present for the birth and this choice was fostered by the midwives. Carrie's birth was in the middle of the night and so her other children were not awakened and present as planned. Lisa's other children were all "right there at the time he was born." (Lisa, line 313). And Lucy stated that one of her reasons for having a homebirth was so that her son could be present when her daughter was born. Informants also described the involvement of aunts, uncles and sisters at their births; again demonstrating the importance of family to them and to their midwives.

Wholistic

Many women commented on the comprehensive, extensive care that they received from the midwives. One said, "all my needs were always being taken care of. . .the care with

the midwives was far more extensive.." (Carrie, line 1008-1011). The caregiver-client relationship was not confined to physical concerns, but the importance of emotions and psychological care was recognized and addressed throughout the birth experience.

One woman began seeking an alternate caregiver because, "I didn't find that they [physicians] treated the whole person, they just treated you as a patient.." (Amanda, line 40-41). Another woman said, "my biggest motivation was to get all-around care" which would "meet my needs emotionally as well as physically. I'm not just a physical being. I'm an emotional being as well." (Yolanda, line 831 & 803-5).

The midwives' focus on the whole person is aptly described in the following quotes:

> ..a midwife isn't so concerned about your...weight and you know, your weight is okay. Are you feeling okay? (Tina, line 1152-4)

> [one thing] that I really appreciated about a midwife was that they looked at the whole person. It's not just this baby in utero but all of you. (Opal, line 439-441)

Another woman described the emotional care she received from her midwife after having a non-stress test for her post-dates pregnancy. She described this incident twice during her interview, which may be an indication of its significance.

> "..but emotionally I was getting to be a wreck.... there's one time I went in and I just kind of broke down after and [MIDWIFE'S NAME] was right there with me...." (Mary, line 134-7)

Women also described the influence of their own emotions and past experiences on their pregnancies and births. They talked about stress, joy, anxiety, grief, depression, and their dreams separately from the midwife's response. Emotions were significant to many of the informants and the perception of wholistic care offered by the midwives may have attracted some women to them.

Woman-Centred

Several women focused on the individualized care of a midwife as a motivating factor in their choice of caregiver. When describing her reasons for choosing a midwife, one replied, "And for more personalized care....I felt maybe because it was a smaller group that each person was known." (Carrie, line 1185-8). Women made statements regarding the personal, individualized care that they received and that they did not feel like a number or "part of a collective group called pregnant women." (Lucy, line 1028). Tina liked the "little things" her midwife attended to during the birth: "she put hot cloths on my perineum to help me stretch. And she made me tea right after the birth." (Tina, line 585-8). Yolanda described her perceptions:

> they made me feel, even though I wasn't the only woman in the world pregnant...that I was still a very special person who was pregnant. (line 1303-4).

and

> they treated me very much like an individual or a unique person. I wasn't a number, I was Yolanda and I was important to them. (line 1317-8).

Another woman noted:

> ..their clients are people that they get involved with, not somebody whose chart they scan two minutes before they go in....just to refresh them, what they're doing. (Lucy, line 971-4)

A final comment on the nature of the relationship - "..they all know you. They know you personally and so...it was a very good relationship I found." (Amanda, line 1035-7).

One of the elements of woman-centred care is the freedom of the woman to carry out her individual choices regarding her birth experience. This freedom to choose was described by many of the informants and was encouraged and respected by the midwives. Some of the informants talked about being able to do whatever they felt comfortable doing, "[it was] totally up to me." (Mary, line 216); "You just

have the freedom to be able to basically do whatever you want...." (Yolanda, line 376-7). One described the position she was in for labour and said, "so I kind of developed it myself and that seemed to be the most comfortable position...but it worked for me." (Amanda, line 723-5). Another described the open attitude and flexibility of the midwives:

> ..but they were very open to that and they had no problems with the kids coming and if you wanted to video tape or if you wanted to hang from the chandelier, basically, that was up to you. (Carrie, line 1395-8)

Some women described how birth choices made them feel, "it was just really more the birth I wanted." (Tina, line 93). One woman really liked the idea of the birth plan and stated:

> it was like my birth....It wasn't how this doctor delivers. It was, what did I want to do and what did my husband want to do and how did we feel comfortable and how they would help us achieve that goal. (Mary, line 443-7)

She also said that she preferred midwifery care because "I guess it comes down to choices...." (Mary, line 520).

The above comments on freedom to choose were all from women who had midwife-attended hospital births. Perhaps the midwives' respect for individual choices was assumed by the women who had homebirths.

Many of the informants wanted to be involved and in control of what happened to them during their birth experience, and recognized that midwives encouraged this kind of woman-centred care. Part of one woman's choice of a midwife was based on her belief that midwives would allow her to control her experience:

> I guess just their general policy of non-intervention and letting the woman do it herself. I like that. 'Cause I liked having that control over my life with my situations.... (Elizabeth, line 35-7)

Other statements included, "I wanted a lot of control in my labour and my delivery." (Yolanda, line 1234) and "I wanted to be really involved with my birth." (Tina, line 18). In contrast, women described "the things they do to you" and that "things were just happening to me", which implies a lack of control and a forced passivity. One woman stated her primary reason for choosing a midwife:

> So it was for my care; basically that was why I chose a midwife because I didn't want my body to be ruined... [that] was probably my primary thing and I didn't want all these things being done to me that I didn't want to have done. (Opal, line 635-9)

Women described various scenarios in which they experienced caregivers being pushy, controlling and blatantly coercive. One woman found her midwives to be "a little pushy" and "more pushy than I would like them to be" about breast-feeding. (Amanda, line 842 & 845). Another woman described a situation which occurred following delivery in a previous birth:

> They [nurses] made me get up and have a shower. Well, I kept passing out because I had just lost all this blood and I felt awful...but they couldn't give me a sponge bath because somebody else needed that room right away. (Tina, line 741-45)

Yolanda described a situation with a nurse on the postpartum ward regarding supplementing her newborn baby, in which the nurse was adhering to a strict feeding schedule and Yolanda wanted to feed on demand. Yolanda did hold her ground, but only after a long discussion and threats by the nurse to go find the doctor.

The final scenario is described by Karen, whose baby was overdue and who was contemplating an induction of labour. Her midwives were not present when this incident occurred:

> The worst thing they did was six people crowded on Harry out in the hallway away from me and they picked on poor dad, and they said that you're

> almost for sure going to lose your baby and you might lose your wife, too. He came back in, bawling his eyes out. (Karen, line 177-181)

Some women realized that they should have or did have the ultimate control. One said, "You are in charge of this birth, not the doctor." (Tina, line 1044). Another woman, for her third birth, declared:

> I knew it was up to me and there [were] going to be people there, but nobody could push the baby out <u>but</u> me.. (Lucy, line 1111-2)

One woman didn't initially realize that "there was as many choices as I found out" or "how much power I could have." (Mary, line 501 & 507). During her prenatal visits with the midwives, various choices were discussed and she made her own decisions about her experience, unlike her previous care with a physician.

There was one informant who described control in a slightly different way. During her labour, her midwife had control.

> ..she [midwife] kind of just took control. She took over and you know, that's what you needed. (Amanda, line 205-6)

It is not certain how this transfer of control occurred, but Amanda obviously found it to be helpful and was not offended.

Ongoing Relationship/Continuity of Care

Almost all of the informants commented on the ongoing nature of the midwife-woman relationship and how the relationship developed over time. Some gave examples of lack of continuity of care in the past or stated that having the same caregiver for the entire birth experience was a major reason for choosing a midwife. Lucy sums up the experience and value of an ongoing relationship with her caregiver:

> I think it's the continuity of seeing one person, particularly when it came to the labour and delivery, not having people changing shifts and knowing who was going to be there. Very few

> doctors will guarantee anymore that they'll actually be the ones that are going to attend your birth. And then they make their visits afterwards...There's just something good about seeing the same person all the time.. (Lucy, line 977-985)

Women expressed the desire to have the same person attend them and preferred the "before, during and after care" that the midwives provided. One said, "I warted the person who was going to be delivering my baby [to] be the same person who had been caring for me from the beginning of my pregnancy." (Yolanda, line 790-1). Other women described the importance of an ongoing relationship with their caregiver, and the assurance it gave them.

> ..that continuity of care also made me feel more assured that this person knows my course of events, it's not someone new coming in and doesn't know quite exactly what has transpired. (Opal, line 521-5)

> After I got to know the midwives a bit I started to realize, hey, this is something I really want. And this is important. I mean with a doctor, you can have a relationship with a doctor, but he or she might not be at your birth. (Elizabeth, line 804-8)

Several women described instances of different caregivers, shift changes and lack of continuity of care. A woman in the hospital-based midwifery program thought that "an improvement would be..between two midwives, you would know who you were going to get." (Tina, line 164-5). She had had a negative experience at the end of her pregnancy because of conflicting measurements of her fundal height by different caregivers, and stated that "ideally, we would have rather seen one midwife all the way through." (Tina, line 828). Another one said, "..every midwife I talked to had a different decision about whether or not it was the head or the butt [referring to the presenting part]". (Yolanda, line 275-7).

One woman in the hospital group realized that "It doesn't matter if your doctor said, 'Oh, no problem.' Your doctor's not going to be there. It's the nurse who's going to be taking care of you while you're in there." (Carrie, line 587-9) She wanted to "see if there was a difference having the primary caregiver there throughout your labour." (line 44-45). She concluded that continuity of care was present among the midwives because they all had the same beliefs.

Many of the informants commented on the fact that the relationship continued into the postpartum period. Women described the midwives "coming in to see me" or "checking on me" or "calling me at home." Midwives maintained contact with their clients either through home visits, hospital visits, or phone calls. The women in the hospital group went back to their midwives for a six week postpartum checkup and most commented that it was with the same midwife that had attended their birth.

Trusting Relationship

Some women described birth as a vulnerable time and they wanted to have a caregiver whom they could trust to be there with them. Amanda described the benefits of a trusting relationship:

> I knew I [could] count on these people and you learn to trust them....you kind of built a relationship, which is I think, something that you really need during that time when you're so distressed. (Amanda, line 85-90)

Some informants described their own or other's feelings of previous betrayal by their caregiver at the time of birth. Two birth accounts and the woman's reactions follow:

> She said her first birth, she felt that the doctor really knew her and really knew what was going on. And when the birth actually happened, the doctor put her in stirrups, gave her an episiotomy. It was totally different....and she felt so

> betrayed....because she had said to the doctor, 'This is what I don't want.' (Tina, line 1260-1272)

> And you've placed all this trust, you've talked to this professional every month and [said]... 'I'm scared or I want to do this, I want to do that.' And you get down to it and he's not there. So what do you do? You're at the mercy of others.... (Mary, line 737-742)

One woman was aware of the potential for the caregiver to char . his/her mind at the last minute, especially in regard to an episiotomy, and wanted to avoid this kind of situation. She explains:

> At the time when you're about to push and yeah, it feels like you <u>are</u> going to split and he says, 'Well, you know, we should do an episiotomy.' 'Do whatever you have to do' is what so many women have told me. And I guess I didn't want to be in that kind of a vulnerable [situation].... (Opal, line 650-655)

Trust is described as a feeling that develops in a relationship. Informants stated that one "learns to trust" and trust is something that "builds" over time. Trust in one's caregiver involved "honest answers" and their "looking out for my best interests." Trust was described as listening to and believing in one's midwife, especially in circumstances that require sound clinical judgement. Two women describe this kind of trusting relationship with their midwives. After transfer to hospital, during the last few minutes of her labour, Elizabeth was afraid to push when the doctor said she could:

> It was like what he said didn't even phase me. But [MIDWIFE'S NAME] said to me, 'Elizabeth, it's okay, you can push.' And I heard her....and it was just because I trusted her. I didn't trust him, I didn't know him from...never had met him before. But I trusted her and I think that again was because of the continuity of care and the relationship that we had built. (line 152-159)

> I guess it's the trust that you have in them that if they do suggest something, for example, a

> hospital transfer that it's to a point where...they can't do more for you and that then maybe there is an intervention that's necessary. (Lucy, line 1009-1015)

Several other women mentioned that they had "a lot of trust" or "complete trust" in their midwives.

Women also described the results of this trusting relationship, which were security, comfort, lack of anxiety and feeling relaxed. One said, "I just felt a whole weight was all lifted off. It felt really good, I just felt good about it from the beginning." (Lisa, line 51-3). "We were just more comfortable and relaxed...just that our feelings were being acknowledged...." (Renee, line 128-9). One woman described that the midwives "..made you feel so relaxed...and comfortable with yourself". (Amanda, line 76-77).

Deep Commitment

Almost all of the informants described the relationship with their midwives as a strong bond, and gave examples which illustrated how important the midwives' presence and support were to them. One women described the relationship this way:

> ..they're sort of friends as women are friends. Not necessarily as close neighbours, but you sort of establish a camaraderie....you're all in it for the same purpose - healthy outcomes for babies, hopefully with a good experience somewhere along the line. And it's sort of doing your little bit together to help change the world. (Lucy, line 1297-1304)

Other phrases used to describe the relationship were, "we became friends", "we really bonded with her", "a warm, fuzzy feeling" and "in tune". There was a social aspect to the relationship as well. Women could drop in on the midwives to chat, and the hospital program hosted teas and reunions for the women who had participated. Suzette wrote a letter of appreciation to her midwife for her "warm-hearted" manner during a particularly difficult birth. Tina had a midwife

who shared her faith and said, "That was really special to me" and described the bond that developed between them. Yolanda expressed this bond poignantly:

> I think there's a special bond that I have with all of the midwives who were there...I have a bond with each and every one of them for their hours that they put in with me. And to know that they were involved in such a special time for me...the birth of my child, makes me emotional and makes me realize that probably for the remainder of my days I will always remember my midwives because it was such a positive experience. (Yolanda, line 1391-1400

Other women recounted touching examples of the strength of their relationship with their midwife. Elizabeth saw a different primary midwife for her second pregnancy, but during her labour she explains that:

> the relationship that I had built with [FIRST MIDWIFE] was still so strong, even though I hadn't seen her for the prenatal...that when she would say things to me during the labour...I would still cue in to her. I heard [OTHER MIDWIFE] too, but there was still something about [FIRST MIDWIFE] that I listened to her. (Elizabeth, line 496-503)

Karen also described the bond with her midwife.

> And I looked through the mask and there was [MIDWIFE]'s eyes. . .But there were her eyes. And I relaxed 'cause I knew she'd look after me. She'd be there for my well-being. And she was. (Karen, line 1260-4)

In these examples, the midwife's eyes and her voice conveyed strength and trust.

A number of women in the hospital-based midwifery program stated that they would have followed the midwives if the program had moved or changed hospitals:

> I would have gone to any hospital as long as they were there. Like after I had met them and gone to see them, if they would have said, 'Okay, we're switching hospitals', I would have said, '"Okay, I'm there!' Like it really didn't matter the hospital as much as <u>them</u>. (Amanda, line 1052-1058).

Another said, "I would have gone wherever they would have had it. [program]" (Mary, line 613). Yolanda underwent an external cephalic version to "ensure that I could have the midwives follow me throughout my pregnancy." (Yolanda, line 238-9) because midwives in the hospital program could not deliver babies in breech position.

Other women demonstrated their commitment to midwifery care by paying for their services, which are not covered by health care. One said, "...I had to pay for [it] all...I don't regret it but...." (Suzette, line 835). Another stated that "From a financial point of view having a midwife isn't something that we can afford to do lightly. To me, it means enough to have a homebirth to find the money." (Lucy, line 1093-1095). Elizabeth described her commitment to the midwives:

> ..[we] think they're wonderful and want to support them in any way we can. We wish we could give them more money. 'Cause I think even at {XX} dollars a birth, I don't think that's very much money. (Elizabeth, line 834-7)

She also realized the personal sacrifice that her midwife made in attending her 36-hour birth experience while she was breast-feeding her own infant. Another comment regarding the midwives' sacrifice of time to be with their clients is made by Lisa:

> The night she came down, she came in a blizzard and her car broke down..But um she stayed the first night and I didn't have Amy until the next afternoon and she stayed that night again and it was well into the day before she left. (Lisa, line 506-511)

From these descriptions, it is clear that the women experienced a deep, personal relationship with their midwives, appreciated their time and care, and were committed to them.

One final quote captures the essence of the midwife-woman relationship and was made by Mary. She stated that

having a midwife "is the only way to go for women" and described her reasons below:

> ..having the caregivers there that are experts in what they do, but compassionate. Understanding. [They] don't look at this as birth number 591 or...they really make it an experience for you. This is birth....This is giving life and they're there to share that with you....They're there to help you and share in that joy. And struggles sometimes, too but...they're here to help me and they're not just there to catch the baby, they're there to guide me along and make me aware of what's really happening. I just find it very personal.... (Mary, line 638-656)

Personal Outcomes

One of the final questions asked during the informants' interviews was whether the choice of a midwife had influenced them personally or changed their views about childbirth and/or midwives, and if so, to describe in what way. Women talked about increased confidence in their ability to give birth, to mother, and in themselves generally. Many mentioned the responsibility that they had taken for their own health and the resulting reliance on self as opposed to medical professionals. Others talked about healing, empowerment and an extremely enriching birth experience as outcomes of choosing midwifery care. Opal's quote encompasses many of the feelings that women expressed about their experience:

> ..I feel that I'm a much richer person for it. Because I feel that I was in control of my pregnancy, of the outcome...getting all this information from my midwife about nutrition and about what's good and I felt very much that this is <u>our</u> baby, this is going to be <u>our</u> experience....just the empowerment... And I think that that really helped me to become a stronger person and much more sure of myself that I could do it. And my body is capable of doing it. And I felt that that really gave me a real boost to be a mother. (Opal, line 906-925)

Many women described their feelings of "confidence in myself as a woman", "very capable", "self-confidence", and "faith in myself and my body". Some women explained the midwives' role in this feeling of confidence:

> She waited and was calm and made you feel that you could do it... She always gave you that confidence. I think that does an awful lot, it's really, really important. And...the doctors I had, they were the opposite. They always made me feel that I couldn't do it. (Lisa, line 235-240).

> ..that's probably the big way that my relationship with the midwives changed me - they gave me confidence in my own ability to be a mother...And just the confidence in being able to give birth....And I guess that gave me confidence in myself, too. (Elizabeth, line 772-780)

Elizabeth described one of her first breast feeding experiences with her midwife present, and Yolanda described her experience with a postpartum nurse. Elizabeth stated that the midwife "totally listened to my instincts" even though she was "really green at it" and that this response made her feel good and gave her confidence. (Elizabeth, lines 747-755). In contrast, Yolanda, who had a hospital based midwife attend her birth, described her interaction as a "struggle" involving the post-partum nurse pushing the baby's head onto her breast and saying, "You need to do this and you need to do that". (Yolanda, lines 594-601).

Many of the informants stated that they had a responsibility for their own birth experience and one woman was quite emphatic about her belief in women's responsibility.

> I also believe that the women have a responsibility to take care of themselves and to eat right and to exercise and not sit around and drink pop or watch TV or whatever. You can't have a healthy birth if you don't take care of yourself. (Lisa, line 546-550)

Lucy described the research and responsibility involved in making the choice of a midwife as an alternative caregiver; 'to go outside of the health care system':

> I feel kind of sad in a way for when regulations [for midwifery] come into effect and for a person to sit back and say, "Well, gee, I think maybe I'll have a midwife...this time" and they don't have to put into it the same thought, soul-searching I suppose...I think I've gained a lot of knowledge about the system, about myself, what I'm capable of.... (line 1047-1054)

Women described various actions that demonstrated their responsibility for their experience. Many did a lot of reading on their own during pregnancy about different topics including nutrition, the safety of ultrasounds and other technologies, and breast-feeding. Several practiced perineal massage at home. Opal said that all the preparations for a homebirth, including sterilizing sheets, made her feel "psychologically ready". (Opal, line 949-951).

Tina described how the midwives encouraged her to take responsibility for her own care during prenatal visits:

> ..you tested your own urine. You weighed yourself. And boy, I remember the first time, I just felt, 'Oh! You mean I can tell what this little strip is doing.' (Tina, line 1163-6)

She also spoke about the midwives wanting to "enable the mom" for their birth experiences.

One woman had described herself as a 'chicken' about childbirth but found that her birth experience changed her views about herself and her health care significantly. She said:

> Now I know I can do it. And I find that I'm less likely to always take that way, like saying, 'Oh...I'll go and take an aspirin or I'll go to the doctor for this.' I think it's just a better way of living. Not going to the drug store for everything and I think it's going to help Heather. [daughter].... So I think I changed in that way. (Amanda, line 761-771)

Other personal outcomes described by some women were feelings of empowerment and healing. One said, "It was probably one of <u>the</u> most empowering experiences I've ever had." (Yolanda, line 1249). Another said, "...it was very healing to have a good experience because I found it...very empowering." (Elizabeth, line 474-5). Renee has the final comment on how her birth experience influenced her personal development:

> ..it relieved a lot of that pressure, that fear, too...like that hate or discouragement or the anger I had about Devon's birth. Elaine's birth relieved a lot of that. Knowing that I could do this without drugs, without...all that stuff. Yeah, I guess it changed me in that way...it lifted some weight, relieved me of some burden. (line 323-329)

The personal outcomes described by these informants are ones of positive growth, increased confidence, self-esteem and reliance on themselves for their health care needs. The significance of these outcomes will be discussed in the next chapter.

<u>The Professional Role of the Midwife</u>

Whether midwives work within an institution or outside of one; as a team or in solo practice, there must be some element of collaboration with other health care professionals. Many of the informants commented on how the midwives interacted with other caregivers and how these professional relationships influenced aspects of their care. Most of the descriptions of professional relationships are from the women in the hospital group. Domiciliary midwives did not have the same degree of interaction with other health care professionals.

The hospital midwifery programme consisted of a team of six or seven nurse-midwives who were employed by the institution. Women were not assigned one primary caregiver, but were cared for by the team as a whole. The programme

was a demonstration project and several changes occurred over time. Initially all women who were interested and met basic criteria were enrolled as participants. Later only one in four women were randomized into the midwifery group; others were referred back to their initial caregiver and were part of a 'control' or comparison group. Informants were participants in the programme at various points in time, and described experiences representing a cross-section. Some informants were participants early in the programme and others were randomized into the midwifery group at a later point. Also, as the programme developed over time, postpartum care provided by the midwives was expanded in scope to include home visits.

Some informants described how the midwives worked as a team and how this unity was achieved. One said that, "you wouldn't necessarily get the same one every time for a visit, but...it would be in your file and I mean they all talked to each other." (Amanda, line 1026-9). Carrie mentioned that the midwives had weekly meetings to discuss each client and therefore were "aware of everything; aware of your birthplan." (Carrie, lines 64 & 69). Another woman perceived that the midwives communicated well with each other:

> ...they seemed to work very well together as a team themselves....they had a very good communication system. They kept very good notes and...before a midwife even came in to see you, I think she had read through your file very intently. And I think they had made personal remarks on there, so even though you hadn't met that particular midwife, they had a little bit more inside information on you.... (Yolanda, line 1276-1288)

Domiciliary midwives also functioned as teams or collectives. Their relationships with each other were described as 'very professional' and it was noted that they "all had to be in agreement" (Karen, line 72) regarding decisions affecting their clients.

W en in the hospital program described their
ions of the midwife's role vis-a-vis the physician.
l women described the presence of an obstetrician
ng their birth. Some stated that he/she "was just in
corner, watching the midwives" (Amanda, line 199) or
sort of popped in every now and then but really kept low
key" (Yolanda, line 435). Another woman viewed the obstetrician's presence as part of the 'standard procedure' and stated, "He just stood back and had to be there, I think, just for the sake of being there." (Carrie, line 91 93).

Several women described the limitations of the hospital environment related to the midwives' lack of autonomy and control, and the philosophical differences between obstetrics and midwifery. One chose a homebirth "because I felt that even though I would have a midwife, the doctor still kind of has the upper hand." (Opal, line 866 8). Tina had been anticipating a positive hospital birth "...in terms of the midwife being in full charge of what was going on." (Tina, line 129). However, she experienced two negative incidents related to conflicting measurements between a midwife and an obstetrician, which caused her to doubt the midwives' ability to advocate for her. She explained why this may have been the case.

> ...because under this program, and it is a pilot project, they basically have to bow down to the obstetricians. I was only one of the very first people in the program. And so they hadn't quite worked out things with the obstetricians. (Tina, line 230-234)

She also suggested that instead of being overseen by obstetricians who are accustomed to high-risk or problem pregnancies, general practitioners be involved with the midwifery program. Carrie stated that, "I hope there isn't always that obstetrician hanging over and hovering in the background" and that the midwives in the program were "not

really autonomous." (Carrie, lines 793-4 & 316). She also wondered how the nurse-midwives could 'switch roles' from being nurses to being "in authority" as midwives.

The woman who had a midwife as labour support for a hospital birth described her midwife's response to the hospital staff:

> ...a lot of people were happy to see her again and she just said, 'I'm not here for a social visit, I'm here to be with Karen'.... Even though she was probably very happy to see these people, she knew what her context was there.... (Karen, line 952-959)

One woman who was transferred from home to hospital for a previous birth was "very pleased at the way the hospital responded to the midwives...." (Elizabeth, line 173). She stated that the nurse in labour and delivery "pretty much left us alone. I guess she felt [MIDWIFE'S NAME] knew what she was doing and would call if she needed her." (line 177-8). However, during her postpartum experience, she "felt as if they were punishing me for trying to have a homebirth. But see, it was a different group. It wasn't the labour and delivery people." (line 214-216). Obviously, the responses of other health care professionals towards midwives and the women for whom they care can differ greatly within the same institution.

Two women described how their midwife sought other professionals when complications occurred. In one case the midwife contacted a physician with whom she worked for a second opinion; in another case the midwife phoned ahead to a hospital to inform them that she was bringing in a mother and baby.

Because midwives in Alberta are not yet a recognized part of the health care system, many women who chose midwives knew how to 'work the system' to obtain various forms of care and treatment. Different strategies were described by informants, either to use medical services

selectively; or to plan midwifery care for a future pregnancy. All informants were asked if they would choose a midwife as caregiver for a future pregnancy and all responded that <u>if</u> another pregnancy occurred, they would definitely want a midwife.

One woman said that while there was no doubt that she wanted a midwife as her caregiver she:

> ...did want to keep in touch with the obstetrician because midwives can't prescribe ultrasounds or other diagnostic tests, at least not at that point in time.... I wanted to keep the connection there. (Lucy, lines 951-965)

Another woman described her strategy for backup care in case of complications with her homebirth. She met with an obstetrician who was recommended by the midwives because if she had any problems during birth, she did not want to have an unknown caregiver.

One woman described her strategy for avoiding interventions with her last hospital birth:

> I was already trying to get away from some of the things...We waited until we thought it was just time, so they wouldn't have time to do anything. We'd just go and have it. (Lisa, line 241 4)

One woman was anticipating moving in the near future and stated that she would need to investigate the midwifery care in that province for her next birth.

Some women who were part of the hospital midwifery project had thought about future options for midwifery care. One said that she could not "go back to just a regular doctor". (Amanda, line 562). Most hoped that the programme would continue and that midwives would be certified. A few had entertained thoughts of hiring a private midwife to attend them, either at home or in hospital. One said she would ask the midwives to recommend a physician whom they respected.

Strategies for the selective use of physicians and contingency plans for having midwives in the future were

mentioned by many informants. These strategies for one's care exist because of the current ambiguous nature of the role of the midwife in the larger health care system.

The Women's Dreams

Informants had hopes and dreams for midwifery, for their own future births, and for women's health care in general. Many of these ideas evolved as a result of their experience with midwives and were perhaps a consequence of their choice. Their ideas on the practice of midwives and their supportive actions towards midwifery will be presented, followed by their own personal dreams regarding birth and midwifery.

Many of the informants described telling their pregnant friends and acquaintances about midwives and recommending that they seek midwifery care. They took opportunities to share their positive experiences with midwives and to encourage their friends to explore this option. One said the "quality of care will speak for itself." (Yolanda, line 1213). Another said, "I think it's the only way to go for women." (Mary, line 628).

While the informants had slightly different ideas as to how midwives should practice, the overwhelming theme was that midwifery should be an available choice for all women. In order to be a truly available choice, women must first be aware that midwifery care exists, and it must be accessible. Awareness of options was described by Suzette:

> ..why we choose a midwife or not is with the information we have. I think many women don't have the information of how it is done in the hospital, [or] what is the alternative...a lot of things they don't know. (Suzette, line 728-731)

The financial cost of having a midwife may limit its accessibility for some women. While the women in the hospital project were not charged for midwifery care, those having midwife-attended homebirths or midwives as labour

support paid for these services. Several women mentioned that it was expensive to have a midwife and one said that probably more women would consider having a midwife "if it was free." (Elizabeth, line 703).

One informant believed that midwives should be "an option for women". She thought that midwives should be added to the health care system "so people can have a choice", but that they not be confined to hospitals. (Lisa, lines 568 & 586). One woman said, "I wish every pregnant woman would do this. I wish it was available to everyone." (Mary, line 769-770). Another said, "I hope that that freedom will be given to women in the near future." (Yolanda, line 1218). One woman who needed to have a hospital birth stated, "But I also have the right to have a midwife." (Karen, line 271). These informants did not think that midwives should be confined either to home or hospital settings, but should be available for women wherever they want to give birth.

Informants also stated that regardless of the setting, midwives needed to have some control. One said that birthing centres could be an option, but only if they were run by midwives. The importance of the midwife having some degree of power is noted in this quote:

> I think it would be nice if people who wanted to have hospital births, who weren't comfortable with the home setting, if they had a midwife that could have some control. (Elizabeth, line 676-8)

A woman who participated in the hospital project said "I don't think what I experienced is what midwifery is going to be...I hope it's not." (Carrie, line 772-3). She hoped that midwives would have more autonomy in the future. One woman thought that midwives could be involved in family planning and fertility management as well as pregnancy and birth.

After their own positive experiences, many of the informants wanted to help other women benefit from midwifery

care. One said "they made a big difference in my experience" and after realizing that not all women had that choice, said "I have to help and I've been active since." (Karen, lines 481 & 479). Many of these women were aware that changes to the health care system were brought about by consumers. Several had taken action towards promoting midwifery and alternatives in childbirth, either by writing letters to governing bodies or by joining local consumer associations. Some were involved in the Alberta Midwifery Task Force, a consumer group working towards midwifery legislation. One woman admitted that she was wary of midwifery regulation because it might limit her choice of a midwife by becoming overly prescriptive regarding midwives' scope of practice.

One of the informants said that it seemed that many women who had received midwifery care went through a period of wanting to be a midwife. Following her first midwife-attended birth, "everything seemed to be living and breathing babies", and being involved with midwives and pregnancy was "always at the forefront of my mind." (Lucy, lines 1285 & 1290). Women interviewed after Lucy were asked if they had ever thought about becoming a midwife. Of the five women interviewed after this point, three had considered it. One said that she had always been interested in birth and "really wanted to be at a birth." (Mary, line 373). Two had briefly considered midwifery as a profession but were concentrating on their families at the present time. In an earlier interview, one woman stated that she wished to become a midwife and was actually working towards that goal. She also shared the information that her grandmother had been a midwife and wondered if there was some kind of biological/genetic link with birth.

Several women described their personal dreams for birth. One had read about a couple who stopped by the side of the road and simply had their baby. She wondered if she

could have a baby by herself without any attendants. Another thought that going into the forest alone and having her baby on a soft bed of moss would be a great thing. One said that ideally, she would like to have the births she really wanted in a hospital in order to project the faith she had in her body onto the system. She wished that her births could make a grand political statement about women's power and strength.

These women had both personal and political dreams about midwifery in the future - for other women and for themselves. They wanted midwives to be an available choice for all women. Many had hopes about their future birth experiences and for some, their bond with midwives may eventually expand into their own midwifery practice.

Summary

The presented data provide a rich description of how these women experienced midwifery. Informants talked about the process of choice and their reasons for choosing an alternative caregiver. They also contributed extensive data regarding their perceptions of midwifery care. Some general reasons for choosing a midwife seemed to be a shared belief in natural childbirth, one's past experiences and expectations, the quality and depth of the midwife-woman relationship and for some women, the location of home as a birth place.

While each woman's birth experiences were unique to her and varied considerably from woman to woman, the general themes outlined above present a picture of the experience of midwifery care in Alberta in and around 1992. One of the most important findings was the impact that the women's experiences with midwives had on their lives. All women talked about positive psychological outcomes such as increased confidence, responsibility for their health care needs and empowerment. These women made a choice that went

'against the majority' of child-bearing women who are cared for by a physician. In the following chapter, the findings will be discussed further and some final conclusions drawn.

CHAPTER V - DISCUSSION, CONCLUSIONS & IMPLICATIONS

Introduction

The original purpose of this research was to investigate the reasons why women chose midwives as caregivers. However, the data obtained from the informants provided more than a description of the process and outcomes of this choice. Of equal importance were the informants' perceptions of midwifery care, evidenced by the amount of information shared during interviews about the relationships with their midwives. As this data was relevant to the research question, it was included in the analysis. The discussion therefore will address both the context of choice and the perceptions of care in relation to the women's experience of midwifery.

The data obtained from a sample of informants experiencing midwifery care in Alberta in 1992 form the basis of this discussion. Informants varied in their chosen place of birth, number of previous births and other characteristics; all chose midwives as caregivers before the implementation of regulated midwifery. The women provided data on why, how, when, and where they chose midwives, and their own and other's responses to midwifery care, resulting in a thick description of their experience of midwifery.

The midwife-woman relationship emerged as a central theme which was viewed sometimes as an antecedent reason for choice and at other times as a positive outcome of choice. Often reasons for choosing a midwife were not explicitly stated, but were revealed by the women's descriptions of their expectations and experiences of midwifery care. These descriptions provided data which addressed the central research question. Women also shared information about how midwives 'fit' into the larger health care system and how the midwives' professional role impacted upon their care.

The informants described their 'dreams' about midwifery which added valuable information about women's desires for future maternity care.

Literature relevant to the findings of this study was examined and will be incorporated into the discussion. Scientific literature from several disciplines was reviewed, including midwifery, nursing, medicine, anthropology, sociology and psychology. The findings from this study will be compared and discussed in relation to other research and potential areas for future research will be recommended. Conclusions will be drawn and implications for clinical practice, research and education will be stated. Strengths and limitations of the study will also be presented and discussed.

The Context of Choice

Context is defined as the circumstances surrounding an act; therefore the context of choice will refer to all circumstances surrounding the process of choosing a midwife. Choices are always context dependent as opposed to being made in isolation. The first six categories of the findings will be included in the discussion of the context of choice. These are the process of choice, the influence of location on choice, influencing factors and shared beliefs (experiences and expectations), and responses to choice (reactions of others, going against the majority).

The Process of Choice

The process of choice can be described as intentional, dynamic and individual. Two of the defining attributes of the concept of choice are that it is consciously directed and active. The intentional and dynamic nature of the informants' choice of caregiver will be discussed using examples from different informants to integrate the individual aspect of choice. Choice as intentional addresses the ideas of commitment, purpose and the nature of the search. Choice as dynamic is related to the actions of

becoming aware, searching, finding, doubting and confirming.

Intentional Choice

Informants described the conscious steps they took in choosing a midwife - the choice was not frivolous or taken lightly. Informants generally made an intentional choice, either for an alternative caregiver or place of birth. However, Mary's choice was initially more circumstantial than intentional. Her general practitioner was no longer practicing obstetrics and she was referred to the midwifery programme. She said, "It was because of that circumstance...I can't really say if I would have done it if he had been delivering." (line 34-36). She also stated that going to an obstetrician would be "a waste" because she was "a low-risk pregnancy" and she then intentionally chose midwives.

An overwhelming majority of women in Alberta receive maternity care from physicians, which implies that those women who do not must intentionally seek alternatives. The women in this study were determined and committed to achieving their goal of midwife-attended births. Lucy described the process of "soul-searching" to determine whether midwifery care and a homebirth were the right choices for her. The term 'soul-searching' captures the depth and importance of the choice and its ramifications. Many of the women did extensive reading and investigation of various options. Tina and Lisa changed caregivers during their fifth and sixth months of pregnancy respectively when they found midwives. Yolanda described the painful procedure of having her breech baby turned in order that the midwives could continue to care for her. If her baby had remained in breech position, a physician would have been her primary caregiver. These actions demonstrate the women's commitment to pursuing midwifery care and the intensive nature of their search.

Informants varied in the focus of their intent; some women desired a midwife, some wanted an attendant for a homebirth, others were looking for childbirth alternatives generally and were not quite sure what they were seeking. It seemed that women either consciously chose midwives or rejected conventional care which led them to investigate options including midwives. While the former is a choice of an alternative, the latter is a rejection of conventional care and by default, acceptance of an alternative. Some examples may clarify this subtle difference. Renee told her friends that she wanted a midwife and sought their help in contacting local midwives. Elizabeth's primary intent was a homebirth and as midwives were the only professionals who would attend a birth at home, she chose them to assist her. Amanda knew that she was looking for something, but wasn't sure exactly what she wanted. However, she knew that she did not want to choose the "normal route".

Regardless of the primary intent, most informants were disenchanted with conventional birth; perceived as physician-attended hospital birth, often associated with high rates of medical intervention. Women began questioning the status quo and rethinking the need for medical care during normal pregnancy and birth. Informants described this process differently: Opal became "dissatisfied with the conventional way of birth". Lucy and Yolanda described very cognitive processes of thinking about and questioning the need for various interventions in childbirth. Renee and Lisa became disenchanted after negative personal experiences and began seeking alternatives to conventional birth.

Dynamic Choice

The precursor to choosing is becoming aware that a choice exists. While this may seem blatantly obvious, some informants were not aware that midwives were actively practicing or that midwives even existed in Alberta. As noted in the previous discussion regarding intent, some

women 'stumbled upon' midwives while seeking general birth alternatives.

The other antecedent condition in addition to awareness is the availability of choice. Presently in Alberta the practice of midwifery is dependent upon geographical location such that in one major city midwives practice primarily in domiciliary settings, and in another city midwives practice almost exclusively within a hospital setting. Albertans living in rural areas have even less choice of caregiver. Thus the type of midwifery care available to a woman is dependent upon where she lives. Because midwifery care is not covered under provincial health care, financial constraints may restrict the availability of this choice for some women.

The Search

Some informants were very aware of the practice of midwives and finding a midwife to care for them was not difficult. Friendship networks and consumer organizations often provided women with information about midwives. Karen, Lucy, Renee and Carrie were involved in the 'childbirth community' and used these connections to locate midwives. The informants who participated in the hospital-based midwifery programme required a physician referral for midwifery care. This did not seem to be problematic for the women in this study.

For other informants, the search was difficult and demanding. Opal was vigilant and "always kept her ears and eyes open" for information about midwives and birth alternatives. Tina and Lisa initially sought support from the medical community for their needs and met with several un-accommodating caregivers before discovering midwives. Women most often heard about midwives through 'word-of-mouth' with other women, rather than from the larger medical community. Lisa was given a contact phone number from her

local public health unit, but "they told me not to say where it came from." (line 188)

Doubts

After finding a midwife, the process of choice did not necessarily cease. Many informants described experiences of doubt or mixed feelings at various times. These feelings were related to a number of considerations, including the caregiver's personality, role and practice, the place of birth and the use of technology. Doubts about the caregiver will be discussed below, while doubts about birth place and technology will be discussed under the sections on location of birth and beliefs respectively.

Feelings of doubt were often a result of unmet expectations - expectations of an exclusive one-to-one relationship with a midwife, of midwives acting as advocates or acknowledging a woman's fears. Some informants had doubts about a particular midwife or group of midwives in terms of experience, knowledge and skill.

Women used a number of strategies to quell or allay their doubts. Elizabeth and Renee settled their doubts by changing primary midwives; Suzette and Opal gained confidence in the midwives' knowledge and skills; Mary came to know each midwife in the team over time. During her pregnancy, Tina doubted the midwives' ability to advocate on her behalf. While she did not completely resolve this doubt, she chose to "stick with the midwifery programme". In the end, her midwife proved to be "just wonderful" and she described her birth experience in very positive terms.

The purpose of doubt is to challenge one's views, resulting in either a stronger acceptance or a rejection of them. This study was retrospective and all of these informants maintained their choice of a midwife. However, in other women, feelings of doubt may have caused them to reject their initial decision.

Two informants described experiences that confirmed their choice. Opal valued the midwives' sensitive treatment of infants and this was reinforced after seeing newborn babies being cared for during a hospital tour. Suzette accompanied a friend to a hospital birth and became more convinced that she did not want to have a baby in the conventional way. It is evident that choices may be confirmed and strengthened, as well as doubted.

Many informants related very deliberate and detailed processes of choosing. Eight informants chose a midwife for their first birth experience while the others did not 'discover' midwives until their third or fourth pregnancy. Choice was also dependent on the availability of midwifery care, especially in regard to location and cost. Obviously the process of choice was very individual for each woman and each birth.

Influence of Location on Choice

As noted throughout this study, the women's experience of choosing a midwife was the focus; women having both home and hospital births were interviewed in an effort to concentrate on the choice of caregiver. Half of the informants in this study had homebirths and half hospital births as their most recent birth experience. Choice is made within a situational context, and in this study it was obvious that the location of birth was a significant factor in the women's choice. In fact, some of the informants found it difficult to discriminate between choosing a midwife and choosing a homebirth.

For most of the informants, the primary choice was for a midwife, followed by or concurrent with the choice of location. However, for Elizabeth and Suzette, the first choice was for a homebirth, followed by a midwife as caregiver. Elizabeth later stated that after meeting with the midwives she realized that the relationship was as important as the homebirth aspect. An informant from the

hospital group commented that the location of the midwives' practice was not as important as the midwives themselves.

All informants were aware of birth place options and had considered advantages and disadvantages of each in the process of choosing. The women in this study cited feelings of increased control and the comfort of the home environment as primary reasons for choosing homebirth. Informants described control in two slightly different ways - control over who attended your birth and control over what happened to you generally. The comfort and intimacy of one's home and the presence of family were also perceived as advantages of homebirths. These reasons are consistent with findings from other studies that have explored the choice of an alternative birth place (Abel & Kearns, 1991; Klee, 1986; McClain, 1981; Sacks & Donnenfeld, 1984; Searles, 1981; Schiff & LaFerla, 1985).

Abel and Kearns (1991) studied planned homebirths in New Zealand from anthropological and geographical perspectives. The qualitative data from their informants revealed that three dimensions of experience - control, continuity and the familiarity of home - were most commonly described as reasons for the choice of home as birth place. Home was identified as a 'haven' and was perceived as a place of security and emotional significance (Abel & Kearns, 1991, p. 828).

Control

The issue of control has been studied by a number of researchers in relation to choice of birth place. Women choosing out-of-hospital births were found to have a strong internal locus of control using varied methods of measurement (Bassingthwaite-Thiessen, 1988; Fullerton, 1982) including the Multidimensional Health Locus of Control scale (MHLC). In an American study, the results of the MHLC were not significantly different on the dimensions of chance and internal locus of control for a group of women planning

homebirths compared with a group planning hospital births (Schiff & LaFerla, 1985). However, during personal interviews and in a ranking exercise, differences between these groups were found in attitudes of control. The majority of subjects in the homebirth group ranked the ability to be in control as most important and interview responses focused on issues of control, while no one in the hospital group ranked the ability to be in control within the top three reasons for choice.

While nurse-midwifery and homebirths are recognized within the health care system in many states in America, Canada has not recognized midwifery until recently, which may account for different findings between American and Canadian studies. Bassingthwaite-Thiessen's (1988) study was carried out in Alberta prior to midwifery legislation; the women who chose out-of-hospital births were more likely to have a strong internal locus of control in order to make such a 'radical' choice.

In this study, the concept of control was not described exclusively by the women choosing homebirths, but was common to all who chose midwives. Many previous studies on control either examined the influence of location independently of the influence of caregiver (Littlefield & Adams, 1987; McClain, 1981) or did not discriminate between the two choices (Klee, 1986; McClain, 1983). Perhaps an internal locus of control is present in women who choose alternatives to conventional care, encompassing both the caregiver and the place of birth.

Perceptions of Risk

The primary informants in this study did not explicitly describe their perceptions of risk related to birth place, but assessment of risk was implied by some. Lucy was living in cramped quarters and would have chosen the option of a birthing centre had one been available, but decided that home was still a better choice than hospital. Tina lived

outside of the city and thought that she lived too far away to have a homebirth. Carrie briefly considered a homebirth but had a hospital birth and was discharged within twelve hours. These examples, while not explicitly describing perception of risk do imply an assessment of risk related to place of birth.

In one study it was found that women's perceptions of medical risk do not necessarily conform with "mainstream obstetric doctrine" (McClain, 1981, p. 1033). Women evaluate social and psychological risks as well as medical risks when considering the best environment for childbirth. Schiff & LaFerla (1985) found that awareness of perceived risks differed between home and hospital birth subjects. Home birth subjects believed there were both psychological and medical risks with hospital delivery including loss of control, being rushed, the presence of strangers and medical risks involving unnecessary interventions. Many of the hospital birth subjects perceived no risks in hospital; a few considered incompetent medical staff to be the only risk.

Location of birth is not limited to the choice of home versus hospital. Women could chose a particular hospital or chose between a birthing room or a more traditional labour and delivery room. Two women in this study selected the hospital that was operating the midwifery programme partially because they had experienced other births there and felt comfortable. Amanda chose the birthing room within the hospital for its intimate, comfortable surroundings which she perceived as conducive to her labour. Other women have described the relaxed, warm, home-like environment and the avoidance of transfer for delivery as reasons for choosing a birthing room (Klee, 1986; Mackey, 1990). The influence of location was very significant for all of the informants, regardless of where they ultimately gave birth.

Influencing Factors & Shared Beliefs

In the presentation of data, influencing factors for the choice of a midwife were grouped as external and internal factors. This classification was drawn from Murphy & Harvey's (1989) study on choice of childbirth method after Cesarean. They described external factors as sources of information and support and internal factors as one's beliefs, previous experience and locus of control. While this was done for ease of organization, it is difficult to discern in a study of this nature which factors arise from within a woman and which from without.

External Factors

For the latter part of this century, health care professionals have conventionally been the chief source of formal information on childbirth. However, the informants in this study did not mention that professionals had been overly influential upon their choice. Instead, they were influenced by informal networks of friends and acquaintances and various media. The strong influence of books such as Leboyer's Birth without Violence, Mendelsohn's Mal(e)practice and Confessions of a Medical Heretic and other books on alternative birthing was evident in the descriptions of some informants.

Consumer groups like the Alberta Midwifery Task Force, the La Leche League, and consumer groups for safe alternatives in childbirth were also instrumental in exposing informants to alternative ways of thinking about health and birth. It is not known whether readings and involvement in the 'childbirth community' preceded or occurred as a result of the choice of a midwife. The majority of the informants had been interested in birth and health care alternatives prior to seeking midwifery care and all became pro-active towards midwifery following their experiences.

It is interesting that although media coverage on midwifery has frequently been negative, for Yolanda and Renee it was just this exposure that heightened their interest in midwives. Several informants in this study were health care workers whose professional experiences of conventional birth were not positive and caused them to start questioning 'medicalized birth'. In the researcher's experience, it is not uncommon for health care professionals to seek midwives to attend them in birth.

Internal Factors

A woman's attitudes, beliefs, expectations, feelings about past experiences and locus of control are important influences in making birth choices (Chute, 1985; Klee, 1986; McClain, 1983; Murphy & Harvey, 1989). Many beliefs and values about women, health, birth and sexuality are embedded in one's cultural background. All of the informants in this study were born and raised in Canada. It is therefore difficult to describe the role of culture on one's childbirth beliefs because all informants were part of the same basic culture.

Many of the women in this study described childbirth as normal, natural and physiological and believed in "letting nature take its course". The belief in minimal use of technology and interventions during pregnancy and birth was also prevalent. Several informants commented on the importance of emotional bonding between a mother and her newborn immediately after birth. There were no definitive differences in beliefs between informants choosing hospital births or homebirths; all valued a natural approach to birth. Perhaps the women in the homebirth group may have been more vehement in their beliefs, but attitudes were consistently favourable towards birth as a normal process.

Aaronson's study (1987) on the "fit" between care provider and client suggested that congruence of beliefs between the woman and her caregiver, rather than the

substance of those beliefs was the most important factor in determining compliance. Carrie described being "on the same wavelength" with her midwives. While data from this study corroborate that midwives and their clients held the same views about childbirth, an interesting question remains. How did the informants know that midwives were "the guardians of natural birth"? Although this perception is commonly held, the source of women's constructed knowledge is not known. L. McCreary-Burke, a graduate student in anthropology is currently studying the cultural transmission of women's knowledge regarding childbirth.

Klee (1986) compared attitudes of women who selected hospital alternative birth centres (ABCs) with those who selected homebirths with lay-midwives and conventional hospital births with obstetricians. Primary caregivers in the ABCs were either certified nurse-midwives or physicians. It was found that there were differences in the overall ideology of childbirth among groups. While women choosing the ABC shared some critical views of conventional birth with the homebirth group, their beliefs in the "authority of hospital obstetrics and the expertise of physicians" (Klee, 1986, p. 9) were congruent with the conventional birth group. In the United Kingdom, a survey found that "many women choose a hospital delivery because they are convinced of the intrinsic danger of childbirth." (Shepperdson, 1983, p. 405). These studies focused on beliefs regarding the place of birth without describing the potential effect of the caregiver.

Expectations

Expectations of one's caregiver are significant factors affecting choice. Tina was surprised to find that the physician did not arrive until delivery was imminent and sought a midwife as a familiar person who would be with her for the entire birth. Yolanda was aware that a physician may not arrive until the last minute, and thought that a

nurse could effectively care for her during labour and deliver the baby. Other expectations of midwives included the role of advocate, acknowledgement of fears and personal concerns and a shared belief in natural childbirth. While these were not explicitly stated as expectations, it is evident that the informants did expect their midwives to act in certain ways as caregivers.

In one study, parents ranked the most important characteristic in selecting an obstetrician as 'a sincere concern for the patient' (Brien, Haverfield & Shanteau, 1983). For some informants in this study, it was a perceived lack of concern and caring by previous caregivers and a perceived presence of concern by the midwives that was instrumental in changing caregivers in favour of a midwife. Throughout her interview Amanda described the midwives as 'very caring' in comparison to a previous caregiver. Lisa disliked the way she was treated by physicians in previous births and decided to choose an alternative. It is apparent that their expectations of a caregiver were previously not being met.

Locus of Control

Another potential determinant affecting choice is one's locus of control. The purpose of this study was to describe, not to measure; however, many informants talked about the issue of control as being influential in their choice of a caregiver. Elizabeth, Yolanda and Tina strongly desired to be "in control" and "involved" in their own birth experiences and they perceived that the midwives encouraged their participation.

An internal locus of control has previously been discussed in regard to choosing an alternative birth place. Chute (1985) and Aaronson (1987) state similar findings regarding the choice of an alternative caregiver. Chute analyzed the expected and experienced participation of subjects in their own birth experience. She found that

women attended by nurse-midwives viewed themselves as the most important individual in contributing to the satisfaction of their experience. This is analogous to a high internal locus of control on the Multidimensional Health Locus of Control Scale (MHLC). Using the MHLC, Aaronson found that nurse-midwife clients scored higher on internal locus of control and obstetrician clients scored higher on chance and powerful others locus of control.

Perceptions of Risk

As noted in the discussion on birth place, one's perception of risk may have a role in making and justifying birth choices. Women often perceive medical risks differently from social or psychological risks (McClain, 1981) and then weigh risks within a situational context. McClain (1983) also found that women may 'bolster' their choice by discounting risks and magnifying benefits of their chosen childbirth service. This complex cognitive phenomenon was not described by the women in the present study, but may be an area for further study.

Women who choose midwives may perceive risks differently from women who chose conventional caregivers. In a study that examined "fit" between clients and caregivers, the subjects who chose nurse-midwives placed a higher value on 'an exciting life' while obstetrician's clients valued 'a comfortable life' more highly (Aaronson, 1987). Aaronson proposed that those women who valued excitement may have selected a less traditional caregiver for this reason. In this study Carrie was "curious" about the hospital midwifery programme and wanted to try it out.

Responses to the Choice of a Midwife

The reactions of others including the women's male partners, family, friends and health care professionals were reported in the previous chapter. Reactions varied from supportive/positive to neutral to disapproval/negative. The women's responses to these reactions were also described and

various strategies for dealing with negative reactions or justifying their choice were revealed. Generally speaking, the reaction of others was an important factor in the overall context of choice; in making, maintaining and justifying one's choice.

Reactions of Male Partners

All informants in this study had received positive support from a male partner in their choice. Suzette did not have a male partner during her most recent pregnancy but had received his support for a midwife in previous pregnancies. Lisa stated that it was necessary to have the support of at least one other person, preferably your partner in the choice of a midwife. Elizabeth, Carrie, Opal and Yolanda had husbands who shared their beliefs about natural childbirth and were involved in and affirmed the choice of a midwife from 'day one'. Other women described their partners as 'needing time to come around'. In some cases, reactions changed over time as the men received information and gained understanding through communication with their partners. Renee described the ongoing communication with her husband as they discussed the choice of a midwife and then a homebirth.

It appeared that the majority of informants initiated the choice of a midwife and their partners accepted it; either immediately and without reservation or after some consideration. Renee demonstrated the subtle progression of influence in the words, "I decided" to "we decided". Another informant said that her husband would accept whatever choice she made, that the choice was hers. Sacks and Donnenfeld (1984) found an interesting disparity in how partners perceived the initiation of birth choices. More than half of the fathers indicated that the prospective mother initiated the choice. This finding may be supported by the informants in this study, whose experiences seem to

reflect that birth choices are primarily initiated by the woman, although often without her conscious realization.

The choice of a midwife as caregiver and especially the choice of a midwife-attended homebirth are not mainstream or 'socially acceptable' choices. One researcher found that women and their partners who chose an alternative place of birth "encountered stronger opinions on both sides of the issue...than those making the more conventional choice.." (McClain, 1987, p. 150). There were marked differences noted between the homebirth and hospital groups regarding the reported reactions of others; these will be discussed and potential explanations proposed.

Favourable Reactions

Women who encountered favourable reactions were either involved in a social network of friends who supported birth alternatives or were participants in the hospital-based midwifery project. Several women who had home and hospital births with midwives were part of the 'childbirth community' or had friends who were "pro-birth". Renee, Karen, Elizabeth and Suzette had friends who had experienced midwife-attended births. In a study on the social networks of women choosing home and hospital births, McClain (1987) found several differences. Women choosing homebirths had strong friendship networks comprised of peers who had attended and were supportive of homebirths and these friendship networks were frequently more significant to them than the women's immediate families.

Some women participating in the hospital demonstration project initially encountered shocked responses about 'having a baby at home with a midwife!' However, when the inquirers were told that the birth would be in a hospital with "fully trained professionals", most were relieved and more accepting. Health care professionals seemed to be more supportive of the hospital-based programme as well. Participants in the project required a referral from a

physician, and none of the women in this study found that obtaining this referral was a difficult task. In fact, Tina's doctor initiated her referral and strongly endorsed the programme. While midwives are not perceived as mainstream, hospital births generally are, and the alternative of a midwife-attended hospital birth may be viewed as more 'socially acceptable' in the eyes of professionals and the public at large.

Neutral Reactions

A few informants described indifferent, apathetic and neutral reactions. One woman's mother-in-law simply respected her decision and did not exhibit either support or disapproval. Another woman said that one family member "didn't seem to have an opinion" about her choice. This kind of reaction was perceived negatively as lack of support by some women; or positively as lack of opposition by others. Lisa said that she felt better when people left her alone and did not "bother" her about her choice. Other women from the homebirth group "did not feel a lot of support" and "would have liked more support from people". However, these 'neutral' responses were not described by the informants in great detail; most reactions were either strongly positive or strongly negative.

Misperceptions of Midwives

Common misperceptions about midwives were prevalent among the general public and were also voiced by some health care professionals. Some false assumptions about midwives and their practice included the image of the 'granny' midwife of past generations or the automatic assumption that having a midwife meant having a homebirth. Informants described the widespread lack of awareness of midwives and how they were obliged to enlighten others in order to defend their choice. Carrie said that many people thought that midwifery was "against the law" and needed to be educated about current practice.

Negative Reactions

The majority of negative reactions were usually associated with homebirth, rather than midwifery care itself. Most of the descriptions of disapproval were from the informants who chose a midwife-attended homebirth. Families were concerned about the safety of homebirths and the availability of emergency care in the case of complications. It is noted that disapproval was voiced primarily by family members, not peers, in the descriptions of the homebirth group, which reinforces McClain's (1987) findings on social networks that homebirth mothers often experience lack of support from family members and concomitantly, increased support from friendship networks.

Lisa, Lucy and Yolanda described negative reactions by health care professionals towards 'natural' birth in hospital; planning a homebirth; and allowing pregnancy to extend past 42 weeks gestation respectively. Reactions of health care professionals seemed to be based upon one of two opposing views. In this study, physicians were predominantly supportive of the institutionally-based research project on midwifery care, but were opposed towards more radical alternatives such as homebirth or practicing outside of accepted protocols regarding the induction of labour.

Women's Responses

When women perceived a lack of support or disapproval from significant others, they responded in several ways. Both affective feelings and strategies to protect oneself were described by the informants in this study. These perceptions and cognitive strategies were described in Chapter IV under the theme <u>going against the majority</u>. Several informants stated that they felt alone and singled out because of their choice. Women could interpret this feeling negatively and wonder whether they were "odd" or "the only one" who had these beliefs. Alternately, they could view this feeling in a positive light and feel

"special" and part of a "select group" receiving midwifery care.

Several women, especially from the homebirth group, stated that other people's opinions and expectations did not exert a strong influence on them. Lucy noted the difference between her informed and knowledgeable decision and others' mere opinion; she valued the former as the foundation for her choice. Elizabeth felt that she started a "trend" by being the first in her peer group to have a midwife and a homebirth. These statements seem to indicate a strong internal locus of control and a belief in personal power in determining one's experiences. Indeed, the fact that these women did "go against the majority" is evidence of their personal strength in the face of opposition and lack of support.

Strategies

Several strategies to strengthen one's beliefs and to garner support have been discussed above, including association with other like-minded women, seeking information to confirm one's beliefs and educating others about birth alternatives. Four women in the homebirth group described strategies of protection. For example, Renee did not perceive any negative reactions and surmised that she likely "told the right people". Neither Renee nor Elizabeth told their parents about their plans until after the birth was 'successfully' completed. They explained this action by saying their mothers would "just worry". Opal also exhibited caution and prudence in sharing her choice with others, especially those whose views were known to be in opposition to hers. While selective sharing of their choice seemed to be an intuitive response by these informants, Lisa and her partner were consciously evasive. Because of negative responses with their first alternative birth, they "decided it was best if people didn't know too much."

Protective governing is a strategy initially described by Corbin (1987) and validated by Harris (1992) in her grounded theory on women experiencing infertility. A collective of studies on women experiencing uncertain motherhood (Field & Marck, work in progress) has also identified this strategy as a cognitive process of self-protection. This strategy seems to be evident in some of the women choosing the more 'risky' alternative of homebirth. They protected themselves from opposition and disapproval by selective and judicious sharing of information with others.

Social Support

The theme of support and the reactions of others seemed to be more pronounced with the homebirth group. Perhaps their choice of a midwife-attended homebirth was perceived as more radical and less 'socially acceptable' than those who participated in the hospital midwifery programme. The term social embeddedness refers to the connections an individual has with others in the social environment (Barrera, 1986) and has been identified as an important component in social support during pregnancy (Mercer & Ferketich, 1988). Membership in support networks may influence perceptions and expectations; in this study some of the women choosing homebirths seemed to be involved in peer-focused social connections while the hospital group may have been more closely connected with their families.

The converse to social embeddedness is alienation or loss of connection with others; the themes of going against the majority and feeling alone may be reflective of alienation perceived by some informants. While none of the informants were deterred from choosing a midwife due to lack of social support, might this occur? Because this study was retrospective, the choice had been made and was carried out, but might lack of support prevent choice for other women?

In summary, there were significant differences between women who chose homebirths and those who chose hospital births in the descriptions and perceptions of others' reactions to their choice. As noted previously by McClain (1987), women choosing more radical alternatives encounter stronger feelings on both sides of the issue. Some of these women were involved in friendships and social networks that supported birth alternatives, but for those who were not, various strategies were utilized to strengthen beliefs and protect themselves from perceived threats.

Perceptions of Midwifery Care

The informants' perceptions of midwifery care will be discussed in relation to the caring relationship between a woman and her midwife. Several authors have examined caring relationships between women and their caregivers, including midwives. This research includes the work of Lehrman and her associates on the content and process of midwifery care (1981, 1991); Swanson's middle range theory of caring (1991); and Bassett-Smith's grounded theory on authenticating the experience of childbirth (1988). Their findings will be compared with those from this study to elucidate similarities and differences. Discussion will be structured around the attributes of the caregiver, caring actions and the nature of the relationship, although the relationship itself is the central phenomenon.

Attributes of Caregiver

The three identified and inter-related attributes of the midwife were known, female and knowledgeable. Part of a midwife's knowledge base is 'female' knowledge or knowledge of women, their bodies, and their experience. To be known, one must have knowledge of the other, a personal knowledge within a relationship. Perhaps the central motif is knowledge - of knowing and being known in feminine and personal ways.

Value of a Female Caregiver

Giving birth and raising children have traditionally been within the female domain and referred to as 'women's business'. During the 18th century, some physicians were called 'male midwives' and were later designated obstetricians (Leavitt, 1986). Except for this usage, the word midwife is usually synonymous with a female caregiver (Morin, 1992). While male midwives do exist in contemporary society, they are few in number and are the subject of much controversy (Kaur & Clasper, 1993).

Several informants valued the empathy exhibited by the midwives and their experiential knowledge about birth and mothering. Yolanda and Suzette felt quite strongly that a male could only ever experience birth vicariously, from an external viewpoint and that it was important that midwives be female. Others found that the midwives' personal experiences with birth and mothering were beneficial in providing sensitive care. Renee felt that "a compassion evolved" from her midwife's own experience of having children. Giving birth to one's own children did not seem to be an essential prerequisite to practicing as a midwife, but being female and therefore having the potential for that experience was certainly appreciated. Perhaps the critical factor is not simply one's sex, but the resulting sensitivity and ways of thinking - gender.

Although Mary was not initially seeking an alternate caregiver, she did state that "it was nice talking to women" and described examples of midwives demonstrating empathy in mothering and family issues. A study on preference for ob/gyn care providers in the United States (Ohliger, 1985) found that women who had previously received care from female caregivers tended to include them in their preferences, but male ob/gyn physicians were preferred and utilized by the majority of respondents. The author also stated that female ob/gyn physicians were not readily

available. Certainly the women's movement has raised consciousness about reproductive health care and many female caregivers are sought by consumers (Barrington, 1985; Mathews & Zadak, 1991).

Midwifery Knowledge

Informants described their midwives as knowledgeable, specialized and experienced in all aspects of childbirth. This knowledge seemed to take various forms and was classified as folk, professional, intuitive and personal knowledge. The term folk knowledge refers to the sort of information that is often passed on by word of mouth among women, not written about in obstetrical texts. Informants shared examples of midwives' suggestions for turning breech babies, their use of herbs and non-pharmacological remedies and other 'tricks of the trade'. Women have traditionally been the keepers and carriers of such traditional folk medicine knowledge (Sharp, 1986).

Midwives also possessed professional knowledge and skills; they were competent in caring for women and babies and in recognizing complications. Women had confidence in the midwives' care because of their specialization in childbirth. Many midwives have had previous training in nursing and other health related fields prior to beginning their practices (Burtch, 1987).

Karen's midwife knew intuitively that for her first delivery, she should give birth in a hospital setting and she did indeed have an unforeseen complication with the third stage of labour (a retained placenta). Another midwife was described as having a 'sense' about a difficult labour. Through personal conversation with other midwives, this intuitive sense is viewed as a valuable form of knowledge and is evident in 'expert' caregivers, which is corroborated by Benner's (1984) work on nursing practice. She classifies an expert practitioner as one with an

enormous background of experience who possesses superb recognitional and perceptual ability (intuition).

The midwives demonstrated personal knowledge of the women for whom they cared; that is, knowledge of the woman as an individual person - body, mind and spirit. This personal knowledge was reciprocal; the midwives had knowledge of the women and in turn, were known by the women. Each knew the other, which created a comfort in the relationship. Knowledge of a woman enabled the midwife to anticipate how she might labour. Tina's midwife was 'in tune' with her and knew immediately that she needed to "settle down and relax" in order to establish effective labour. In a phenomenological nursing study (Tanner, Benner, Chesla & Gordon, 1993) knowing the patient meant both knowing the patient's typical pattern of responses and knowing the patient as a person. These two aspects of personal knowledge were apparent in the informants' descriptions of their midwives.

Because birth is an intimate and essentially a sexual act, known caregivers were perceived to be a familiar and comforting presence during this vulnerable time. Women talked about the importance of having caregivers who were known by name; not strangers. They described the comfort and ease they felt with their midwives as they 'got to know them'. Caroline Flint originated the Know Your Midwife project in England and found that a small group of known midwives provided optimal continuity of care to maternity clients (Flint & Poulengeris, 1986). The benefit of having a named midwife has also been recognized in a recent report of the British House of Commons Committee on Maternity Services and is strongly supported by Flint (1992).

Patterns of Knowing and Types of Knowledge

Midwives were perceived to have a wealth of knowledge, which has been characterized as folk, professional, intuitive and personal knowledge. This integration of

various types of knowledge made the midwife a well-rounded, valuable practitioner, possessing great wisdom. Carper (1978) identified four fundamental patterns of knowing in nursing, which were empirics, esthetics, and the components of personal and moral knowledge. Some of these patterns can be related to the four kinds of knowledge manifested by the midwives. Empirical knowledge is systematically organized and is used to describe, explain and predict phenomena; this is analogous to the midwives' professional knowledge about such things as anatomy, physiology and psychology. She referred to esthetics as the art of nursing, which involves empathy and the "perception of abstracted particulars" (p. 255). This perception is comparable to the intuitive knowledge held by some midwives, while folk knowledge could be viewed as an element of the art of midwifery.

Carper's component of personal knowledge involved the therapeutic use of self which promoted wholeness and integrity in the personal encounter. The principle of reciprocity in relationship was present both in her description and in the women's words of knowing and being known by their midwives. The ideas of reciprocity and knowing the other emerged as significant themes in the midwife-woman relationship. Reciprocity (as demonstrated by patient's gift-giving) in nurse-patient relationships has been examined by Morse (1989) and found to be a necessary part of the therapeutic relationship.

Caring Actions of the Midwife

The five identified actions of the midwife were being there, spending time, supporting, advocating and sharing information. It is difficult to separate the actions of the midwife from the relationship itself; actions constitute both the content and process of midwifery care. However, actions are generally more tangible than attitudes or perceptions and will be discussed in the context of the relationship.

Being there

Being there was described as both the midwife's actual physical presence and her ongoing assurance of presence. Swanson (1991) defines 'being with' as being "emotionally present to the other" (p. 162) in the context of a caring relationship. It is of note that the word midwife means 'with woman' and connotes the physical and emotional presence demonstrated in midwifery care. In this study, Karen realized the essential meaning of the word midwife when she stated, "She was truly the midwife, she was there for me."

Swanson (1991) stated that being with is "becoming emotionally open to the other's reality" (p. 163). Lucy conveyed the midwives' emotional openness during her time of grief in this statement: "They're not afraid to cry with you or touch you or be there." Being there also implies an availability; that even when the midwife is not present, one can be assured of her presence if and when it is needed.

Supporting

Support is a concept used in many different ways, to describe both actions and attitudes. In this study, the women used the word support to refer to encouragement, practical assistance, agreement with beliefs and physical care. Social support has been studied in relation to pregnancy by Mercer and Ferketich (1988), who outlined the constructs of social embeddedness, perceived support and enacted support. Social embeddedness has been discussed in relation to women's social networks, while perceived support is associated with the notion of available help, described above as 'being there'. Enacted support was further defined to include appraisal, instrumental, emotional and informational support, a framework originally developed by House (1981).

Descriptions of support in this category seem to fall under the four kinds of enacted support. Appraisal support

was demonstrated in the midwives' affirmation of such things as freedom in birth and the practice of breast-feeding. Instrumental support encompassed both the midwives' physical touch and her care and presence during labour. Several women commented on the emotional support offered in times of discouragement and distress, such as Karen's midwife leaving her notes about her mothering abilities and her words of encouragement during difficult points in labour. Finally, the midwives offered informational support in the form of suggestions, guidance to literature, and advice. The sharing of information was an important activity and will be discussed as a separate action below.

Spending Time

One informant stated that spending time was equated with interest in her and her baby; many associated more time with better care. There were several facets to the action of spending time, including the actual duration of visits and care, the availability of the midwives and the characteristic of patience, which was especially important during birth. Generally, time spent together encourages knowledge of the other, and strengthens a relationship. One woman stated that short visits are "not enough time to really know what I'm like." In our society, time is a valuable commodity and spending time with someone is an indication of their worth.

The notion of availability was in reference to the perceived openness of the midwives to questions and concerns - "they had time for you". Lehrman (1981) conceptually defined time as the "subjective feeling that the health care provider is unhurried and will vary the period of interaction according to the client's needs" (p. 30). One woman said that she did not feel as if she was imposing upon her midwife; she perceived a willingness on the part of her midwife to attend to her needs. Several women also mentioned the extensive coverage of midwifery care (24-

hours-a-day) as being advantageous. The perceived and actualized availability of the midwives is a recurring theme, and is present in the actions of being there, supporting and spending time with women. Availability implies commitment and dedication to the relationship.

Patience and encouraging women to follow individual rhythms in labour were important components of midwifery care. Several women valued patience and the fact that the midwives were not following a "predestined clock" while attending their births. One woman said that midwives do not give the impression that "you're costing them time". Patience is a virtue and patient waiting on nature's rhythms is a hallmark of a wise midwife.

Sharing Information

Both the content of information and the process of communication was described by the informants. Content was pro-active in nature; midwives anticipated and addressed questions about physical changes in pregnancy and baby care at appropriate times during care. Midwives strongly encouraged women and their partners to read literature on childbirth to make their own informed decisions, and provided lending libraries to their clients. Yolanda especially valued the 'honest answers' and objective information she received from her midwives. Specific content was often directed by the woman in relation to her individual learning needs, reflecting the flexibility and accountability of the midwives' teaching.

The manner in which information was shared was equally as important as the content. Women accepted suggestions from their midwives or 'put their heads together' to resolve problems. Tina valued the self-care encouraged during her prenatal visits, resulting in a demystification of prenatal care. Others perceived an equal footing with their caregivers in that the power and control to make decisions was theirs, in cooperation with the midwife. This mutual

collaboration has been described as participative care (Lehrman, 1981) and is part of the lateral relationship in midwifery care (Morten, Kohl, O'Mahoney & Pelosi, 1991).

The action of information sharing could be compared to informational support, described as advice, suggestions, directives and information by House (1981); and education and counselling described by Lehrman (1981) as the provision of new knowledge and guidance. This pro-active, woman-directed, collaborative sharing of information often resulted in a demystification of 'medical' knowledge and a resulting responsibility and accountability for one's health.

Advocate

The midwives' advocacy role was viewed as a very significant action which replaced the women's need to fight for their birth choices. The need to fight was a result of several complex factors, including the technocratic view of birth, control held by others and the vulnerability of women in labour. Women realized either from experience or expectation that the times of labour and birth were not conducive to speaking out for one's wishes. As Simkin (1991) stated: "A woman in labour is highly vulnerable. Her most private body parts are exposed, she is in pain; she sweats, trembles and moans..." (p. 210). This is not the time to fend for one's choices; however this is often when unwanted interventions occur - when women are dependent.

Women also stated that their husbands and partners appreciated the midwife's care and were relieved that the burden was no longer entirely 'upon their shoulders'. While fathers have been encouraged to be involved in birth, unfair expectations have often been placed on men in terms of acting in multiple roles - as labour coaches as well as supportive partners (Chandler, 1992).

The perceived need to fight was common to women in both the hospital and homebirth groups, but their strategies

differed. Some women perceived that a midwife would act as their mediator within the hospital system and advocate for them. Other women wanted to avoid the need to fight completely and therefore avoided 'the system' by choosing a midwife-attended homebirth; the action of advocating was not as prevalent in their data. The informants in this study were predominantly strong and well-informed women who were prepared to assert themselves in obtaining their choices. Carrie stated that her previous births were positive "only because I was very assertive" and described that with this birth, the need to 'battle her way' or to 'have her guard up' was not present. If the need for an advocate was so essential to these women, one may ask how much more do less advantaged women require advocates within the system?

Summary and Comparison of Caring Actions

Swanson developed a theory of caring from several perinatal studies (1986, 1990), using phenomenological methods. She defined caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1991, p. 162) and included five categories or caring processes: knowing, being with, doing for, enabling and maintaining belief. Swanson's theory, while not specific to midwifery care, serves to substantiate many of the caring actions described in this study. The actions of being there and being with are similar, as are advocating and doing for. Supporting actions correlate with enabling and maintaining belief, while knowing has been considered as knowledge of and knowing of the other in relationship.

In a study examining the content and process of midwifery care in the postpartum period, therapeutic techniques such as encouragement, clarification and active listening were found to be an essential component of midwifery care (Morten, Kohl, O'Mahoney & Pelosi, 1991). The caring actions in this study were grounded in the

women's words instead of using terminology from professional disciplines, but appear to be similar in meaning.

Nature of the Caring Relationship

The unique relationship between a woman and her midwife was characterized as family-oriented, wholistic, woman-centred, ongoing and one of trust and deep commitment. Most informants referred to their midwives by name and a connection with their caregiver was perceived or described. For all but one informant, the relationship seemed to be a very personal one; Carrie's experience was slightly atypical. In reading through her data, she did not refer to the midwives by name or as her 'heroines'. She had worked within 'the system' and was a self-proclaimed assertive and resourceful woman. The midwives facilitated her choices and provided a supportive environment for her birth, but had a more peripheral role; she did not describe the intimate, caring relationship the other informants did. Her interview data contained the same themes except for the strong bond and the depth of the relationship.

Family-oriented

In almost all cultures, birth is a social event, marking the transformation of men and women to parents and the addition of a new family member (Davis-Floyd, 1992; Jordan, 1993). In this study, midwifery care was not limited to the woman, but included her family in all aspects of care. Informants shared anecdotes of how the midwives interacted with their partners and children during clinic/home visits and at the birth.

Two first-time mothers described how the midwives helped their husbands 'to feel a part of the process' and addressed both their emotional and informational needs. Several researchers are beginning to study the experience of fatherhood in our society (Chandler, 1992; Jordan, 1990). In her study of first-time fathers, Chandler (1992) found that the two men who experienced midwife-attended births

both felt displaced from their role and were not satisfied with their involvement. Although this study focused on the women's experience rather than the men's, this finding was not validated; in fact, several of the fathers shared unsolicited positive comments with the researcher prior to or following the taped interview with the informant.

Children were also included in care - at prenatal visits and at the birth, if the parents desired. As Lisa said, the midwives would "explain stuff to them so that they're not confused or worried." Studies on sibling involvement have found that children who are included in discussions about birth and babies accept the newborn more easily (Spadt, Martin & Thomas, 1990). Children were welcome at birth, both at home and in hospital; however only the women choosing homebirths actually had children present. It may be easier to have children present at homebirths because no transfer and corresponding childcare is involved. Other family members present at births included aunts, sisters, uncles, and parents which demonstrates the family and social orientation of birth.

Wholistic

Midwives and their clients view birth as much more than a medical event - the importance of emotions and psychological care was acknowledged throughout the birth experience. Page (1988) stated that the midwifery tradition of sensitivity to the spiritual and emotional experience of birth protects the precious moments and the 'fullness' of the birth experience (p. 258). Several informants were not satisfied with previous caregivers who did not 'treat the whole person' and were seeking someone who would meet their emotional as well as physical needs.

Many informants shared the prominence of their emotions upon their experiences of pregnancy and birth. These emotions ranged from joy and exhilaration to fear, anxiety, grief and depression. Mary described a situation in which

she and her baby were both physically well, but she was an 'emotional wreck'. Her midwife was with her and demonstrated empathy and support while she cried. This incident made a major impact on Mary, as she referred to it several times during her interview and appreciated the emotional care of the midwives.

The wholistic nature of midwifery care encompassed emotional, spiritual and physical needs, and wholism was an important ideology espoused by midwives and women alike. In contrast, the technocratic view of birth separates the woman and her growing baby; often the safety of the fetus is pitted against the emotional needs of the mother (Davis-Floyd, 1992). Medical language consists of words like uteri, fetuses, hormones and the like; often the woman herself is not mentioned. In the wholistic model of birth, the perspective is one of integration and mother/baby are viewed as an inseparable unit. The conviction that birth is much more than a medical event, that it has great significance in people's lives, is evident in the themes of family-oriented and wholistic care.

Woman-centred

The category of woman-centred care presented data on several areas - the ideas of personal care, individual choices and the concept of control within the relationship. Control will be discussed separately, as it was a theme which permeated many of the findings. Several informants commented on the personalized care of the midwives, that they were known as unique persons, individuals; and were not viewed merely as part of a collective group of pregnant women or as numbers. Two quotes captured this feeling and are repeated here for emphasis:

> they made me feel, even though I wasn't the only woman in the world pregnant...that I was still a very special person who was pregnant. (Yolanda)

> ...they all know you. They know you personally and so it was a very good relationship. (Amanda)

The theme of being known is evident in the descriptions of personalized care. Midwives were also aware of the individual likes and idiosyncracies of the women for whom they cared and attended to 'little things' such as making tea afterwards.

Woman-centred care is also woman-directed care. Many informants stated that their midwives encouraged them to make individual choices about their birth experience. Some made birth plans, which outlined their choices. None of the women having homebirths described a birth plan per se, but in a validating interview, one informant stated that because her midwife knew her wishes she did not need a written document. However, a woman in the hospital group found that making one's choices explicit was a useful exercise for her and her husband. Regardless of birth plan, all informants described an openness and flexibility exhibited by the midwives which encouraged freedom of choice. This freedom and power was appreciated and several described strong feelings of ownership for their experience - "it was more the birth I wanted" and "it was like my birth".

Ongoing Care

Continuity of care was one of the prime reasons given for choosing a midwife. The benefits of an ongoing relationship with one's caregiver are many, but often intangible. Lucy stated that "there's just something good about seeing the same person all the time." Continuity of care gave the women the comforting assurance of a known caregiver at the time of birth. One woman wanted the 'before, during and after care' that a midwife provided. The recurring theme of knowing is interwoven with continuity of care and the ongoing relationship between a woman and her midwife.

Several informants appreciated the fact that midwifery care extended into the postpartum period which is often when new mothers are alone in the community with their newborns, adjusting to their new role and responsibilities. In the hospital program, women received followup phone calls or visits, as well as a six week appointment with the same midwife who had attended their birth. Postpartum home visits were also made to the women who birthed at home. These followup actions may have helped the women to 'debrief' and to review their experience. Bassett-Smith (1988) refers to the entire midwifery relationship as a process of authenticating or validating the mutual experience.

Several informants described situations in which continuity of care had not been present, which led to inconsistencies and general frustration. Some of these were different shifts of nurses, absence of their physician until birth was imminent, and contradictory measurements and assessments. While most of the women in the hospital program felt that this team of midwives provided continuity of care because of their small number, similar philosophies and good communication, Tina perceived otherwise. She recounted two experiences in which a physician needlessly became involved in her prenatal care. She reasoned that these incidents were related to the novelty of the program, lack of confidence in the midwives' abilities and the differing philosophies of midwifery and obstetrics. She (and others) would have preferred one midwife to a team of midwives.

Fragmentation of maternity care is a major problem within the health care system. Page (1988) asserts that continuous midwifery care provides the advantages of safety and accountability as a result of the personal relationship which develops between client and caregiver. The importance of an ongoing caring relationship cannot be minimized;

indeed it may be the most important factor in the midwife-woman relationship.

Trust

Trust was described as a feeling that develops over time within a relationship. Elizabeth stated that she trusted her midwife "because of the continuity of care and the relationship that we had built." Many informants trusted their midwives to be there, to act in expected ways and to protect their interests. Trust involves assurance and belief and is especially important when one is vulnerable. Several women realized their vulnerability to interventions at delivery, specifically episiotomies. Opal trusted that her midwife would not perform an episiotomy, while Elizabeth listened to and trusted her midwife instead of the attending physician while gently delivering her first baby in hospital.

The opposite feeling to trust is betrayal; Mary described feeling "at the mercy of others" when her trusted caregiver was not available at a previous birth. Another woman had trusted her physician and was assured that he knew her and her wishes, but felt completely betrayed when she received all the interventions she had planned to avoid. In contrast, the women in this study felt comfortable, relaxed and secure in the relationship, both during pregnancy and following the birth. Again, trust is a direct result of knowing one's midwife and having faith in her abilities and presence.

Deep Commitment

Both the women and the midwives were committed to the relationship. Several informants demonstrated this commitment. Yolanda underwent an external cephalic version of her breech baby to ensure midwifery care, Mary and Amanda would have followed the midwives to wherever they were practicing. Others made financial sacrifices to have midwives and homebirths. The midwives sacrificed hours and

hours of time spent away from their own families, sometimes attending births in blizzards and in distant places. Midwives and women were mutually committed to the caring relationship and were willing to make personal sacrifices for it.

Pregnancy and birth are intensely significant events in a woman's life. Yolanda spoke about this special bond with her midwives who were present at her birth. She stated that "for the remainder of my days I will always remember my midwives". During her second birth, Elizabeth cued in to the midwife who had been her primary caregiver during her first pregnancy because of the strong bond that was present between them. Simkin's studies on long-term birth memories (1991; 1992) corroborate the strength and accuracy of women's memories of their first birth experience. Hutton (1988) also stresses the importance of the midwife in women's memories, and urges midwives to create positive remembrances.

Summary and Comparison of Caring Relationship

The central theme of the midwife-woman relationship was knowing. The phenomenon of knowing the other was apparent throughout the data on attributes, caring actions and the nature of the relationship. The women repeatedly made reference to knowing their midwives and the positive effects of knowing - trust, continuity of care, intimate and personal care, among others. Knowing is reciprocal - women both knew their midwives and were known by them. Bassett-Smith (1988) described this process as 'mutual engagement' which is "a reciprocal process of intense involvement between the midwife and birthing woman." (p. 110). She further stated that engaging implies that the midwife and the woman are "in tune with each other, fitting in, having a sense of rapport, and at ease with each other." (p. 110). Her definition was substantiated by the women's words in this study.

Bassett-Smith (1988) developed a grounded theory on the experience of childbirth and described the authenticating process as a framework for midwifery practice. She interviewed both women and midwives and established four intertwined phases of authenticating within the relationship - making sense, reframing, balancing and mutually engaging. Her work provided an impressive description of the unique midwife-woman relationship and generated a promising conceptualization for midwifery practice.

The theme of knowing and being known within relationships can also be compared to Gadow's (1993) work on the relational ethic or narrative in women's health care. She views a relationship as involving "construction of meanings that are mutually agreed upon", in contrast to generalist ideologies. (Gadow, 1993, p. 11). A relational narrative involves the mutual acceptance of both persons speaking, which was evident in the data on woman-centred care. In this study, only the women's experiences were sought, but perceptions of their midwives and the relationship were obvious throughout the data.

Personal Outcomes

Informants were deliberately not asked about their satisfaction with midwifery care; satisfaction with childbirth is a complex multi-dimensional construct and presents many methodological problems (Bramadat & Driedger, 1993; Green, Coupland & Kitzinger, 1990; Sullivan & Beeman, 1982). Instead, they were asked if and how their experience had personally influenced them or changed their views. The answers to this question were in reference to psychological or 'soft' outcomes. The psychological outcomes identified in this study were confidence, responsibility for health care, empowerment and healing.

Confidence

Increased confidence was described by informants in several ways - confidence in one's ability to mother; confidence in one's body and its ability to birth; and confidence in oneself as a woman. Elizabeth and Opal felt that their positive birth experiences empowered and encouraged them to be confident mothers. Lisa described confidence as a reciprocal process: "She [midwife] gave you that confidence...and then you felt that you could do it." She viewed the midwife's calm and patient presence as instrumental in instilling confidence. Another woman appreciated that her midwife "listened to my instincts" about breast-feeding and mothering, which in turn gave her confidence.

Responsibility

Responsibility and ownership for one's experience were mentioned by several informants. Responsibility could take the form of keeping oneself physically healthy, informing oneself about various interventions and techniques, or soul-searching to determine the best choices for one's birth. Midwives encouraged responsibility throughout care - Tina was taught to test her own urine and weigh herself at prenatal visits; some practiced perineal massage; almost all informants did extensive reading on childbirth options. The change in Amanda was quite remarkable. She had viewed herself as a 'chicken' before her midwifery experience and subsequently became less reliant on medicine in favour of a "better way of living". This increased self-reliance extended to her new daughter's and her husband's health care as well as her own.

Several women talked about their experience as being '<u>my</u> birth' or '<u>our</u> birth', implying ownership and control. While the technocratic model of birth tends to place not only the control but also the responsibility within the hands of medical professionals, the midwifery model allows

the woman both the control and the corresponding responsibility for her experience (Davis-Floyd, 1992). Chute (1985) found that women choosing nurse-midwives were more likely to view themselves as the most important individuals in their birth experience which implies an internal locus of control and personal responsibility.

Hopes and Dreams

Some informants also described hopes and dreams about midwifery for their own and others' future births. These thoughts may have evolved as a consequence of choosing a midwife, the strong bond they experienced with midwives and their desire to share this opportunity with others. The dreams revolved around the issues of availability and accessibility of midwifery and demonstrated the womens' altruistic desire to share the positive outcomes they experienced and associated with midwifery care.

Significance of Birth

Some informants described their births as extremely empowering experiences and both Elizabeth and Renee stated that their positive births were healing. For Renee, her second birth relieved some of the anger and discouragement of her first experience and was a significant event in her personal development. The immense impact of a negative birth experience on a woman's psychosocial development has been documented by Cohen and Estner (1983) and others.

Birth is a highly significant event in a woman's life. It brings new roles, responsibilities and perhaps even a test of her femininity. Simkin's studies (1991; 1992) on women's memories of their birth experiences highlight the powerful effect that caregivers may have on this event in a woman's life. All of the women in this study described detailed actions and words of the midwife and shared the emotions that the relationship evoked. The significance of a woman's birth and the powerful influence of her midwife is summarized by Caroline Flint:

> A woman never forgets her midwife. Years after the actual event she will be able to remember with clarity what the midwife said, what the midwife did, how the midwife reacted. How the midwife treats the woman can affect the woman's perception of herself, her feelings about herself as a mother, her concept of herself as a woman...The midwife sets the scene for the emergence of a new family. (Flint, 1986, p. 1).

Control

Control was discussed by all informants throughout the study as an important theme. Control was discussed in relation to the location of birth, control over one's birth experience and control held by the midwives, usually within an institutional setting. Like choice, control is a term which is used frequently and often indiscriminately, and can have different meanings. Also, choice and control are closely related, as some degree of control is necessary in order to make a choice.

Control within the Relationship

Data on control were found in the category of woman-centred care. Informants talked about their freedom to choose and their desire to be involved and in control of what happened to them. In contrast, some talked about things that 'had been done to' them in the past, implying a perceived lack of control. The concept of control is pivotal to the midwife-woman relationship. The advocacy role of the midwife necessitates assuming some control over a situation when the woman cannot, for whatever reason. The need for a trusting and committed relationship with one's caregivers is related to accepting and believing in their ability to 'manage' difficult situations; situations in which they may need to take control.

While most of the informants desired a large measure of control over their birth experience, which was reflected in their statements of personal responsibility, Amanda stated

that she needed 'someone to be in control' when she could not. The birth of Amanda's baby was slightly premature, which may have caused heightened anxiety and fear, resulting in the midwives taking a larger measure of control over the situation. Different degrees of control were perceived and desired by individual women. Mary was pleasantly surprised when she realized how many choices and how much power she had over her birth experience. Tina stated that "you are in charge, not the doctor" and Lucy knew it was 'up to her' - no one else could push her baby out.

The Issue of Control

Annandale (1987) studied dimensions of control in an American free-standing birth centre. She questioned the hypothesis that if childbirth occurred naturally with female non-physician providers, women could be more in control of their care. She argued that this hypothesis is based on two mistaken assumptions: that women are both willing and able to take control, and that childbirth occurs within a vacuum, unaffected by ideologies about technology and the role of women. Not surprisingly, she found discrepancies between women's stated desire for control and their actual behaviour in the birth context. While control over decision-making was cited as a reason for choosing birth-centre care, women perceived their controlling role in relation to 'control of self' and over individual health maintenance.

The problem is in viewing the concept of control in isolation. Obviously, control is embedded in politics and culture. In this study, there were differences between descriptions of the homebirth and hospital groups in terms of control. Because the relationship with the domiciliary midwives was simpler ie. essentially between the woman and her midwife, there was less discussion about control. However, the situation in the hospital setting involved the woman, her midwife and the bureaucracy of the institution. The addition of the hospital setting invites another

powerful source of competition for control over birth. The rules and bureaucracy of a hospital institution diminish the control held by both caregivers and their clients.

Competition for Control

In this study Tina commented on the lack of autonomy and advocacy by her midwives and the differing philosophies of obstetrics and midwifery as limitations within the hospital-based program. Opal chose to avoid the hospital completely because she thought that even if she had a midwife, "the doctor still has the upper hand". Carrie also realized the limitations of the hospital midwifery program in that the midwives "were not really autonomous." Annandale (1988) examined strategies used by midwives to 'accomplish' natural birth in the same birthing-centre mentioned above. Because of the need to conform to obstetrical guidelines, the midwives used a number of balancing strategies, some of which involved control over their clients. Rothman described the dilemma of midwives within institutions:

> The American midwife is placed in an extraordinarily demanding position, caught between the needs of physicians who control the institution in which she may work and the needs of the clients she serves. She seeks to maintain her professional identity, while balancing these two forces. (Rothman, 1981, p. 155-6)

Richards (1982) concludes that the fundamental relationship between a woman and her birth attendants must be altered; too often it is a hierarchical power relationship. The essential problem with studies that examine collaborative decision-making in childbirth (Mertick, 1991; Sullivan & Beeman, 1982) is that the power relationship remains unquestioned. One of the primary antecedents to choice is the freedom or power to choose. Therefore, until this unequal and restrictive relationship is corrected, it is irrelevant to discuss choice. The issue

of control is complex and insidious and lies at the heart of many controversies and conflicts in maternity care.

Women's Strategies vis-a-vis Midwifery

Midwives in Alberta are not yet a recognized component of maternity care and the nature of their role remains ambiguous. Women demonstrated a number of strategies in terms of midwifery care within the larger health care system. Many were very aware of 'the system' and how to utilize various caregivers to obtain treatments and care. For example, midwives do not have the jurisdiction to order ultrasounds, diagnostics or lab work; some informants preserved connections with physicians for this reason. Neither do midwives have the authority to admit women to hospital; therefore some women in the homebirth group sought back-up care from physicians in the event of complications necessitating transfer to medical care.

In a previous birth, Lisa waited until she thought delivery was imminent as a strategy to avoid medical interventions. This and the other strategies seem to reveal these women's desire for control and responsibility for care. Women were motivated and knowledgeable about the maternity care system and demonstrated determination in achieving their goals within and outside of the system.

Many of the informants became politically active in the spheres of midwifery legislation and childbirth options following their experience with midwives. This was a strategy for their own future births as well as for other childbearing women to have access to midwifery care. All informants stated that they would choose a midwife for a subsequent pregnancy and several had considered contingency plans in the case of the hospital midwifery program discontinuing or midwives not being readily available. Informants were unanimous in their belief that midwifery should be available to all women, in both home and hospital

settings. Strategies to achieve this end included membership in the Alberta Midwifery Task Force and consumer organizations for safe alternatives in childbirth, and writing letters to governing political bodies calling for midwifery legislation.

Of twelve informants, five had considered becoming midwives themselves. This may also be reflective of a strategy to achieve change through personal action. A study is in progress to examine the process of becoming a midwife and potential factors influencing that decision (Rempel, work in progress). Perhaps women who have had positive experiences with midwifery are motivated to become midwives and continue the crusade in that manner.

Conclusions

In this study, the experiences of twelve women who chose midwives were analyzed and discussed. The initial research question was to determine the reasons for women's choice of a midwife and findings were related to two general content areas - the context of choice and the perceptions of midwifery care. The findings were not overly surprising to the researcher and did not differ greatly from anecdotal accounts and her personal experience. However, the value of this study is its systematic confirmation and validation of the experience of choosing a midwife and the resulting perceptions of the midwife-woman relationship.

Choice was context dependent and was viewed as an intentional and active process. Informants demonstrated personal determination and a strong commitment to obtaining midwifery services in the face of both tangible and intangible barriers. By choosing a midwife they went 'against the majority' of people who receive maternity care from physicians. Some were disenchanted with conventional birth in our society and were influenced by their friends, related literature and personal experience to seek an

alternative. Other influences affecting the choice of a midwife were the location of birth, shared beliefs in natural childbirth and social support for or against one's choice.

The cognitive strategy of balancing was evident in women's description of their various choices. Balancing is related to one's perception and assessment of various risks. Some women accessed certain medical services ie. ultrasounds while receiving midwifery care which demonstrated a balancing of different models of care and technology. Another strategy described by some informants was 'protective governance' in which they balanced significant others' desire for information with their need for emotional security when they anticipated opposition to their choice.

Control was an important theme throughout the study - a woman's locus of control was influential in the process of choice and almost all informants desired control over their birth experience. Control was exercised by both the women and the midwives in different situations. The midwife-woman relationship was essentially woman-centred and woman-directed but within the hospital institution, both midwives and women tended to lose control and autonomy. The freedom to exercise one's choice is essentially a matter of control; lack of power is a serious issue underlying many choices related to childbirth.

The midwife-woman relationship was described in terms of the attributes and actions of the midwives and the nature of the relationship as perceived by the women. Knowing emerged as a central theme in this relationship. The midwife was a known presence, she was knowledgeable about childbirth and the woman for whom she cared, and she offered continuity of care within the relationship. The relationship itself was characterized as family-oriented, wholistic, woman-centred, ongoing and one of trust and depth. Page (1988) supports five essential principles of

modern midwifery care: continuity of care, respect for the normal, enabling informed choices, recognition of birth as more than a medical event and family-centred care. Each of these principles was validated in this study as the women described their perceptions of the midwifery care they had received.

The women in this study described positive personal outcomes related to their experiences with midwifery care. Many gained confidence in themselves as women and mothers. Embarking on motherhood with increased confidence in oneself and one's abilities should be a desired outcome of all birth experiences. Some informants had not felt this way in the past and found that subsequent midwife-attended births were empowering as well as healing events in their lives.

Another related benefit of experiencing midwifery care was increased self-reliance and responsibility for health care. Midwives encouraged informed choices and personal responsibility for one's birth experience. This sense of ownership and control for one's health influenced not only the woman's attitudes, but often her entire family. In light of the significant role that midwives had in creating these positive outcomes, the potential benefits of midwifery care are far-reaching and of great magnitude.

Limitations of the Study

Because of the present context of midwifery in Alberta, these informants represented a unique population. Women choosing midwives before their sanctioned legal regulation are unlikely to be typical consumers of maternity care. These women were studied for precisely that reason. It should also be noted that the type of midwifery care experienced by these women may not be the model of midwifery implemented in the future. The intense personal relationship between these informants and their midwives may

not be possible if midwives' caseloads increase and regulation restricts their practice.

Informants had diverse childbirth histories, with the majority of informants being multigravidas and two being primigravidas. Some had experienced only midwife-attended births, some both midwife and physician attended births. Choice of birth place also varied among informants. The sample was deliberately selected to represent a wide range of past childbirth experiences and to represent both home and hospital midwife-attended births. However, the sample was relatively homogeneous in terms of cultural background. All informants were born in Canada and therefore it was not possible to examine potential cultural differences. It is likely that the experience of choosing a midwife is somewhat dependent on culture and its influence on one's perspective of birth.

Because this study was a beginning exploration of the experience it was restricted to female informants. Informants described their male partner's roles and feelings to some extent, but these views were obviously second-hand. It is likely that differences in perceptions would exist for men and a comparable study seeking men's perceptions would be a valuable counterpart to this one.

Finally, the study was retrospective and examined women's experiences within approximately one year of their occurrence. Many childbirth studies are retrospective and may be influenced by the 'halo effect' (Bramadat & Driedger, 1993) but recent studies of women's childbirth memories (Simkin, 1991; 1992) have shown that up to twenty years following their first birth experience, women's memories are generally reliable. In addition, the process of choice was viewed as active and ongoing, therefore a retrospective study had the benefit of assessing the total experience following its occurrence. Perhaps a series of repeated prospective and retrospective interviews with informants

would be the optimal method to delineate the process of choice and also to compare those who followed through with their choice of a midwife with those who did not.

Implications for Research, Education & Practice

The findings from this study have strong implications for the profession of midwifery in the spheres of research, education and practice. There are also implications for health policy makers and other health professionals with whom midwives practice in a collaborative manner.

Research

The present study was carried out in the specific historical and political context of Alberta in the early 1990's. While some findings may be unique to time and place, the process of choice and the perceptions of midwifery care may be more universal. There is a need for similar studies to be undertaken in a variety of settings and with different populations.

The results of this study provide a multitude of perceptions of what midwifery care is and should be. Further research into the views and desires of consumers of maternity care must be undertaken to ensure that midwifery practice is responsive to their changing needs. Midwifery is viewed as a partnership between a woman and her family and her midwife. Certainly the perspective of each partner in the relationship must be sought. Much of the research to date has examined the perspective of the client and the caregiver separately. Bassett-Smith's (1988) grounded theory on midwifery practice presents a beginning attempt to explicate the unique midwife-woman relationship. Further research into this relationship from both women's and midwives' perspectives is necessary to contribute to midwifery's body of knowledge.

Because the profession of midwifery in Canada is just beginning to develop, more research into the nature of

midwifery is needed. While an international definition of a midwife exists, there are different interpretations and practices among nations and health care systems. All professions hold a body of knowledge and skills specific to that profession. The essential nature and the unique functions of midwifery must be explored and substantiated in order to fully describe midwives' scope of practice.

As noted, midwives care for not only the woman but her family and significant others in the context of the caring relationship. This study assessed only the woman's perceptions and experience but male partners and other family members could be studied in a similar fashion to determine similarities and differences.

Another area for future research is the cognitive process of choice. Women in this study described various strategies for justifying and maintaining their choices and the theme of balancing was evident in several areas. The studies by McClain (1981; 1983) on different perceptions of risk present initial work on some of the determinants of choice in the context of childbirth. Gender-related and social factors related to choice could be explored in different populations.

Education

As described by the informants in this study, the public was grossly misinformed on the subject of midwifery practice. Several women took the opportunity to enlighten their friends and family about current midwifery practice but the lack of knowledge caused some of them undue stress and social isolation. Midwives and midwifery supporters must undertake education of the general public in the areas of:

a) legal status of midwifery in Alberta at the present time
b) midwives' professional training
c) midwives' scope of practice and practice settings, and
d) the advantages and drawbacks of midwifery care.

The women in this study described their midwives as knowledgeable experts in childbirth. Midwives' knowledge was further characterized as folk, professional, intuitive and personal, the combination of which created an expert practitioner. Curricula for midwifery education must address each of these areas. While intuitive and personal knowledge are difficult to 'teach' in the traditional sense, nonetheless, these components must somehow be demonstrated and conveyed throughout midwifery education. Folk knowledge is rarely considered to be essential in professional education, but perhaps through apprenticeship models and course electives in herbal therapies, homeopathy and other non-traditional therapies this type of knowledge may be learned. Midwifery education should include courses from the arts, sciences and humanities to promote a well-rounded and sensitive practitioner.

Educational programmes are also potent factors in the socialization process of becoming a professional and impart many attitudes and values. The underlying philosophy of midwifery and other theoretical concepts should be a necessary part of midwifery education. Currently the process of becoming a midwife and the factors which influence this process are the focus of a research study. Findings related to the socialization of midwives may influence midwifery education in the future.

Clinical Practice

This study has many implication for the practice of midwifery in a Canadian setting. All of the informants voiced strong feelings on several fundamental points. Firstly, midwifery care should be available to all women; secondly, midwives should not be restricted to either home or hospital-based practice and finally, regardless of practice setting, midwives should have a measure of control and autonomy. These views were strongly held by the women in this study. Many of them were active in consumer-based

groups for midwifery legislation or safe birth alternatives and were strong and vocal supporters of midwives.

At present, midwifery is not an available option for many women due to several factors which restrict choice - lack of awareness, financial constraints, geographical setting, lack of support for women's choices and current health care policies. In addition, the technocratic model of birth is pervasive in our society. The women in this study overcame many of the hurdles preventing choice and took a stand by 'going against the majority.' Such measures should not be required for women to attain their choice of caregiver for maternity care.

Women in this study experienced midwifery care in both home and hospital settings. While some differences were noted, the midwife-woman relationship was essentially the same irrespective of setting. Women should have the option to choose not only their caregiver, but their intended place of birth. By choosing a midwife for care, women should not have restricted choice of birth place. Both the choice of caregiver and place of birth should be based on an informed choice by the woman and her family.

Finally, midwives must have an autonomous role. Because the nature of midwifery is currently ambiguous, midwives were received very differently by other health professionals. Two women in the hospital-based project felt especially strongly that midwives needed to have a measure of control and autonomy in their role. While midwives work in collaboration with other health professionals, the care of normal pregnancy and birth should be their unique domain of practice.

The Midwifery Regulatory and Advisory Committee (MRAC) is currently developing recommendations which are anticipated to increase the accessibility and availability of midwifery care to women in Alberta by regulating midwives. This committee is also making recommendations

about practice settings for midwifery which are expected to include home, birth centre and hospital settings. The model accepted by the province of Ontario and planned for Alberta is a woman-directed model of care in which the woman chooses her intended birth place and is attended by her midwife in that setting. The recommendations of the MRAC will profoundly influence the practice of midwifery in Alberta and it is hoped that the issues of availability and accessibility will be in keeping with the wishes of the women in this study.

One of the central themes in this study was knowing - the reciprocal knowing of the other within the midwife-woman relationship. The principle of continuity of care was probably the most important component in establishing a personal relationship with one's midwives. An ongoing relationship is built over time and involves trust and knowledge of the other person. This knowing within relationship was a central theme and recurred throughout the interviews.

Some informants had a single primary midwife with a partner, while those in the hospital-based group were cared for by a team of six or seven midwives. Several informants described the team approach taken by this group of midwives in positive terms but would have preferred one or maybe two primary midwives. Tina especially described instances of lack of continuity of care within the hospital-based midwifery team and proposed that having a primary midwife would be an improvement to the programme.

Since continuity of care seems to be essential to the practice of midwifery, how can it best be achieved? British maternity services are now advocating that "every woman should be able to get to know a midwife during the antenatal period who would be with her in labour and deliver her baby." (Flint, 1992, p. 26). That having a known midwife for ongoing maternity care offers optimal care is only now

being officially recognized by the United Kingdom government, although many women and midwives have known this for years. Ideally care could be provided by one or two named midwives, perhaps within a larger group practice. The importance of having a named, and therefore known midwife cannot be underestimated and is the essence of the unique midwife-woman relationship.

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APPENDIX A1 - ADVERTISEMENT

The Choice of Midwives for Maternity Care

A registered nurse and student midwife from the University of Alberta is conducting a research study on women who choose midwives for their maternity care. If:

a) you have received the care of a midwife within the last year (attendance at your birth and prenatal and postpartum care),

and

b) your baby was born between two and twelve months ago,

You are invited to participate in this study. Please call (403) 425-1273 for more information.

(This advertisement was placed in midwifery clinics in Edmonton and the spring 1993 issue of the Alberta Midwifery Task Force Newsletter)

APPENDIX A2 - LETTER FOR INFORMANTS

Project Title: The Choice of Midwives for Maternity Care

Researcher: Annita Damsma, R.N. M.N. Candidate, University of Alberta
Phone: (403) 425-1273

The purpose of this study is to ask women about their reasons for selecting a midwife to provide care during pregnancy and childbirth. You must have chosen a midwife for prenatal care and a midwife must have assisted you with your birth. If you choose to take part in the study, you will be interviewed once or twice. Your first interview will be done in person and will last about an hour. It will be set at a time and place that is best for you. A second interview may be needed to help me understand things you have told me. It can be over the phone and will probably be shorter than the first. During the first interview, I will ask you to tell me why you chose a midwife, and to describe your experience with midwifery care. You will also be asked some questions about yourself and your childbirth history. The interviews will be tape-recorded but a number will be used on the tape to identify you and not your name.

A secretary will listen to the tapes and make typed copies of the information. Only the researcher and committee members will read the typed copies. Except for the researcher, none of these people will know who you are and they will not share the information on the tapes with anyone. Your name, address and the consent form will be stored in a locked cupboard, separate from the tapes. The tapes and the typed copies will also be kept in a locked cupboard and only the researcher will have keys to these. The tapes will be destroyed seven years after the study is completed. When this study is finished, a report will be written. This report may contain some of your words, but your name will not be used. A make-believe name will be used for you and also your midwife, if her name appears on the audiotape.

You are free to take part in this study and you can choose to leave at any time, and refuse to answer any question. You can also withdraw information at any time, and ask that it not be used in the report. If you tell the researcher about any problems or concerns that she feels should be shared with others, she will discuss it with you first. There are no direct benefits to you by taking part in this study. Some of the information you share may help women to know more about midwives and the care they provide.

If you have questions or concerns about the study, you can call the researcher at the number above at any time. Thank you.

Annita Damsma

(This was sent to selected women who had participated in the Hospital Demonstration Midwifery Project, with the addendum: If you are interested in responding, please send the stamped, pre-addressed response which is enclosed and you will be contacted within the next few weeks.

APPENDIX B - INFORMATION LETTER

Project Title: The Choice of Midwives for Maternity Care

Researcher: Annita Damsma, R.N. Phone: 425-1273

The purpose of this study is to ask women about their reasons for selecting a midwife to provide care during pregnancy and childbirth. You must have chosen a midwife for prenatal care and a midwife must have assisted you with your birth. If you choose to take part in the study, you will be interviewed once or twice. Your first interview will be done in person and will last about an hour. It will be set at a time and place that is best for you. A second interview may be needed to help me understand things you have told me. It can be over the phone and will probably be shorter than the first. During the first interview, I will ask you to tell me why you chose a midwife, and to describe your experience with midwifery care. You will also be asked some questions about yourself and your childbirth history. The interviews will be tape-recorded but a number will be used on the tape to identify you and not your name.

A secretary will listen to the tapes and make typed copies of the information. Only the researcher and committee members will read the typed copies. Except for the researcher, none of these people will know who you are and they will not share the information on the tapes with anyone. Your name, address and the consent form will be stored in a locked cupboard, separate from the tapes. The tapes and the typed copies will also be kept in a locked cupboard and only the researcher will have keys to these. The tapes will be destroyed seven years after the study is completed. When this study is finished, a report will be written. This report may contain some of your words, but your name will not be used. A make-believe name will be used for you and also your midwife, if her name appears on the audiotape.

You are free to take part in this study and you can choose to leave at any time, and refuse to answer any question. You can also withdraw information at any time, and ask that it not be used in the report. If you tell the researcher about any problems or concerns that she feels should be shared with others, she will discuss it with you first. There are no direct benefits to you by taking part in this study. Some of the information you share may help women to know more about midwives and the care they provide.

If you have questions or concerns about the study, you can call the researcher at the number above at any time.

Thank you.

Annita Damsma

APPENDIX C1 - CONSENT FORM A

Project Title: The Choice of Midwives for Maternity Care

Researcher:
Annita Damsma
MN/Nurse-Midwifery Candidate
Faculty of Nursing
University of Alberta
425-1273

Thesis Supervisor:
Dr. Peggy Anne Field
Professor of Nursing
Faculty of Nursing
University of Alberta
492-6248

The purpose of this study is to look at why women choose a midwife for maternity care and to attend their birth. The focus is on your reasons for this choice and your experience with midwifery care.

Your participation in this study will involve the following:

- The researcher will interview you one or more times.
- The first interview will be in person. Other interviews may be done either in person or over the telephone, as decided between us.
- Interviews done in person will take place either in your home or a convenient place for both of us.
- The first interview will last about from one to one and a half hours. It is anticipated that second interviews will be shorter.
- All interviews will be tape-recorded by the researcher.

Besides the researcher, only the typist will listen to the tapes, but thesis committee members may read the typed interviews. The tapes and typed interviews will be kept in a locked drawer during the study. The tapes will be destroyed seven years after the study is completed. The typed interviews may be used for further studies but ethical clearance will be obtained prior to their use. The information and findings of this study may be presented at conferences, or published in a scholarly journal. Your comments from the interviews may be used but your name or any material that may identify you will not be used. Both you and your midwife(wives) will be given a make-believe name.

Your participation in this study is your choice:

- You may refuse to answer any question during an interview.
- You may stop the interview at any point.
- You may withdraw from the study at any time by telling the researcher.
- You may not benefit from being in this study. Your participation may help other women in the future.

This is to certify that I _____ (print name) agree to participate as a volunteer in this research project. I am aware of the purpose of the study and what is involved. All questions have been answered to my satisfaction. I am aware that each interview will be tape-recorded by the researcher. I understand that subject to the provisions of the Child Welfare Act all information will remain confidential. If I tell the researcher information that should be shared with another health professional, she will discuss it with me first. I understand I am free to withdraw from the study at any time. I have been given a copy of this form to keep. I can call the researcher at any time if I have questions or concerns.

_____ _____

Participant Date

_____

Researcher

****

If you wish to receive a summary of the study when it is finished, please complete the following:

Name: _____

Address: _____

APPENDIX C2 - CONSENT FORM B

Research Project: The Choice of Midwives for Maternity Care

Investigator: Annita J. Damsma,
M.N./Nurse-Midwifery Candidate,
Faculty of Nursing,
University of Alberta

Thesis Supervisor: Dr. Peggy Anne Field,
Professor of Nursing,
Faculty of Nursing,
University of Alberta

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of this study is to look at why women choose a midwife for maternity care and to attend their birth. The focus is on your reasons for this choice and your experience with midwifery care.

Your participation in this study will involve the following:

The investigator will interview you one or possibly two times.

- The first interview will be in person. If needed, a second interview may be done either in person or over the telephone. Interviews done in person will take place in your home.
- The first interview will last from one to one and a half hours. It is anticipated that second interviews will be shorter.
- All interviews will be tape-recorded by the investigator.

Your participation in this study is your choice:

- You may refuse to answer any question during an interview.
- You may stop the interview at any point.
- You may withdraw from the study at any time by telling the investigator.

There are no direct risks or benefits to you by your participation in this study. The information you share may assist other women in the future who are interested in midwives. Information you share will remain confidential, unless there is risk of harm to your child. In this unlikely case, the investigator will discuss it with you, but will be required to contact a public health nurse for further assessment. She in turn will have a legal obligation to contact the child abuse authorities. If you disclose problems with a health professional, the investigator will discuss further action with you.

Besides the investigator, only a typist will listen to the taped interviews, but thesis committee members may read the typed interviews. The tapes and typed interviews will be kept in a locked drawer during the study. The tapes and consent forms will be destroyed one year after the study is completed. The typed interviews may be used for further studies but ethical clearance will be obtained prior to their use. The information and findings of this study may be presented at conferences

or published. Your comments from the interviews may be used but your name or any material that may identify you will not be used. Both you and your midwife(midwives) will be given a make-believe name.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact: Annita J. Damsma, at 288-1224; or her thesis supervisor, Dr. Peggy Anne Field, at 492-6248.

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

_____
(Name)

_____
(Signature of Subject)

_____
(Name of Witness)

_____
(Signature)

_____
(Date)

A copy of this consent form will be given to you. Please keep it for your records and future reference.

****

If you wish to receive a summary of the study when it is finished, please complete the following:

Name: _____

Address: _____

APPENDIX D - INTERVIEW GUIDE

Can you tell me about your last pregnancy and how you came to choose a midwife?

More specific questions, if needed:

When did you start thinking about midwifery care for this pregnancy?

Who or what influenced you in seeking a midwife?

How did you go about finding a midwife?

Did you reconsider your choice at any time during your pregnancy or birth?

Did the location of birth influence your decision? If so, how?

Can you describe the reactions of your partner/family/friends in your choice?

How did your choice influence or affect you?

* Can you compare the care of a midwife to other caregivers?

* Have you ever considered becoming a midwife yourself?

* In summary, can you tell me your most important reason(s) for choosing a midwife?

(* indicates a question added during data collection/analysis)

APPENDIX E - BACKGROUND DATA FORM

Please Circle:

1) AGE (years)

< 25 25 - 30 31 - 35 > 35

YOUR PARTNER'S AGE (years)

< 25 25 - 30 31 - 35 > 35

2) EDUCATION (highest level completed)

Junior High High School College/University Graduate Studies

3) EMPLOYMENT STATUS

Full-time Part-time Student Not working outside the home

4) OCCUPATION: (either current or previous) _____

5) BORN IN CANADA: Yes/No If No, where did your family come from?

_____

6) Did your mother have a midwife at any of her births? Yes No

Don't Know

****

CHILDBIRTH HISTORY

For each pregnancy, please record the:

Date	Location	Mode of Delivery	Caregiver
	(home or hospital)	(vaginal or C-section)	(midwife, G.P. or obstetrician)

THANK YOU.