Midwifery today

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Midwifery models of care monitor the physical, psychological, and social aspects of women throughout the childbearing years. Technological advances reflect differing opinions of physicians where intervening measures take choices out of women's hands during birth, often neglecting needs turning a natural process into a medical procedure. This essay looks at choices offered to women in westernized countries choosing midwifery models, in stark contrast to experience within hospital settings.

It inspects beneficial impacts midwifery models have on refugee women and the importance of culturally safe midwifery models practiced in midwifery care in Australia. Financial recession threatens to impact on maternity services. This essay discusses this socio-political concern, and birthing women choosing midwifery lead care, its cost effectiveness, and the needs for change in indemnity insurance arrangements in Australia and abroad. With technological advancements, women are offered many choices medically to birth their babies without real reason to opt for such invasive procedures (Block, as cited in Chjnacki, 2010, pp. 3-54). Physician'sphilosophyto pregnancy is common disease oriented focusing on diagnosis and treatment of problematic pregnancies and birth, managing affecting woman and foetus (Rooks, as cited in Chjnacki, 2010, p. 48). In contrast, midwives have a wellness approach to birth applying holistic care, trusting pregnant women and their ability to safely birth their babies where medical interventions are avoided (Hermer, as cited in Chjnacki, 2010, p. 48).

Although midwifery may be recognized as acceptable, the focus seems to surround the thought mother and baby won't have appropriate attention if

something went wrong under their care. Lubic (2010) writes, in Washington USA it has been noted that midwife managed birthing centers demonstrated how midwifery models impact lives of Page 2 of 6 women attending for the better. Women report coming out of care feeling respected and able to take charge of their own pregnancies, supported to birth their babies naturally without interventions. Woman centered care established through continuity of care gains trust and recognizes the other’s spiritual connection with her body and mind enhancing her natural birthing experience (Lubic, 2010). In Sweden, pregnant women are encouraged to remain home until labor progresses to late-stage avoiding unnecessary obstetric interventions. Women report fewer complications than those who are admitted to the hospital for this phase (Carlsson, Ziegert, Sahlberg-Blom & Nissen, 2010, p. 86). It is not understood why women go to the hospital while in early labor, other than throughanxiety, and to hand over control (Beebe et al. , as cited in Carlsson, 2010, p. 87).

This becomes problematic for women and causes doubts about their body’s ability to progress through labour, if monitoring establishes it is not progressing (Eri, Blystad, Gjengedal & Blaaka, as cited in Carlsson, 2010, p. 87). Although labouring at home women felt they shared their uncertainties with midwives who were able to reassure them when in doubt, enabling them to then progress with their labor at home feeling confident with their own bodies progression (Carlsson, et al. , 2010). Carlsson (2010) states women reported feeling relaxed yet strengthened in their home environments, letting labor progress naturally.

Despitehealthissues prevalent amongst refugee backgrounds, access to the appropriate health care can lead to significant improvements in reproductive health in women (Hymes, Sheik, Wilson & Speigel, as cited in Correa-Velez, 2011, p. 14). Refugee women settling in industrialized English speaking countries benefit significantly from midwifery models of care. It seems differences were evident in obstetric outcomes between Page 3 of 6 women and women born in these countries (Small et al. , as cited in Correa-Velez, 2011, p. 14).

Correa-Velez & Ryan (2011) suggest cultural competency or the degree to which these women are cared for, is of vital importance. Women report hospital stays as having a negative impact on their well being and trust levels due to limitedcommunicationand cultural needs not being understood or met. The use of technical devices and lack of explanation for their use throughout labor was found to be distressing (Correa-Velez, 2011, p. 19). Trust, confidence, and overall satisfaction were identified as important factors to women of refugee background and thought to establish through continuity of care (Correa-Velez, 2011, p. 18).

Women centered care improves communication, enhancing a sense of control enabling informed decision making (Harper et al. , & McCourt et al. , cited in Correa-Velez, 2011, p. 14). Relationships built around these midwifery models develop trust for women of immigrant backgrounds, aiding communication where it can be a barrier and interpreters may be needed. The availability of interpreters through community-based practitioners was found to be limited or obtained through clumsy means (Correa-Velez, 2011, p. 16). Maternity services accessed in Australia come from a diverse range of

women with specific needs (Phiri, Dietsch & Bonner, 2010, p. 05). The protection of cultural groups depends on culturally safe midwifery practice. Midwifery models identify women of all cultures as the main focus of care (Phiri, et al. , 2010, p. 109). Cultural safety essentially concerns a large understanding of individualrespect, support, empowerment, and upholding ofhuman rights(Duffy, et al. , as cited in Phiri, et al. , 2010). Open and respectful communication clear and value free is fundamental in recognizing women's requirements when planning individualized care, this is then incorporated into how cultural safe care is Page 4 of 6 instituted (De, et al. , as cited in Phiri, et al. 2010, p. 109). The uniqueness of midwives and women's relationships aids cultural safety, the relationship is enhanced by the continuity of care (Eckermann, as cited in Phiri, et al. , 2010, p. 108). Deery & Kirkham (as cited in Phiri, et al. , 2010, p. 108) acknowledge how Australian midwifery models engage women individually, then respond appropriately to each woman's cultural needs. Evidence shows midwifery driven models of care based on the midwife woman relationship leads to lower use of medical interventions, safer outcomes for mothers and babies and overall satisfaction, all at low maternity costs (Hatem, et al. as cited in Gould, 2011). Yet in the UK, where midwifery based care in maternity services are envied worldwide, the financial recession threatens to be the largest risk (Gould, 2011). This highlights the need for midwifery models to be implemented and supported by all medical avenues, otherwise, maternity services risk being pushed into large hospitals, where production line maternity care will be prevalent at costly effects (Gould, 2011) explains.

This change would see an amalgamation of midwifery, medical and management structures, having the potential to make long lasting impacts on the future of midwifery lead care where it becomes lost amongst medical models (Gould, 2011). The Australian College of Midwives, (ACM, 2008) outlines how pregnant women and midwives suffer through the lack of professional indemnity insurance offered to midwives practicing privately. Sadly registered midwives frustrated at being unable to work to their full scope safely in private practices are choosing to stop practicing.

Midwifery lead care is only available to a small number of women, as only a few midwives work this way (ACM, 2011, p. 3). Research suggests midwives find their models extremely rewarding and those Page 5 of 6 who have left the midwifery profession would return if they were able to work under such midwifery models safely (Curtis, as cited in ACM, 2011, p. 3). Recent Federal Government recommendations in Australia recognize the need for midwives to take on primary care roles, and are considering changes to funding and indemnity insurance arrangements (Sutherland, et al. 2009, p. 637). Significant midwifery shortages particularly in rural areas combined with rising fertility rates could present significant reform challenges keeping maternity services under pressure if it continues unresolved (Australian Health Workforce Advisory Committee, as cited in Sutherland, et al. , 2009, p. 637). With some state based policy initiatives supporting midwifery care in the public sector, it seems women choosing ongoing care offering midwifery models through pregnancy, birth, and postnatally still remains in the discussion (Sutherland, et al. 2009, p. 638). Governments, health care providers, and insurance companies limit maternal choice (Hermer, as cited

in Chojnacki, 2010, p. 48). Hermer (as cited in Chojnacki, 2010) suggests as pregnancy progresses in America, limitations for the women's birth options increase. A woman's choice as to where and how she birth's her baby may greatly be affected by the governing parties of a particular state (Hermer, as cited in Chojnacki, 2010, p. 59). Midwifery models of care offer women greater choice reflecting their own spiritual, religious, and feminist beliefs.

It cannot be assumed how highly such values be ranked, and when in care of physicians, as patients it seems there is much misunderstanding (Cohen, as cited in Chjnacki, 2010, p. 51). This essay shows supporting evidence that midwives should be sole care providers for women experiencing normal pregnancies. Health care providers need to move away from such medical models of care relating to pregnant women, understanding that it is in fact normal for women to have babies. Evidence shows that women Page 6 of 6 f refugee history acknowledge midwifery models provide continuity of care that is needed for ongoing support during pregnancy (Correa-Velez, 2011, p. 13). This also applies to cultural safe models offered by midwives, and the ongoing relevance it has on Australia's multicultural nation (Phiri, et al. , 2009, p. 105). It is vital that these midwifery models become supported through government backing, enabling midwifery care to become a choice all women have the privilege to make through their own individual circumstances.

In accordance with my research, the harsh reality is lack of insurance coverage may limit women's options towards such significant happenings as birthing their babies, regardless of what is the best interest for them physically, mentally, and spiritually (Law, as cited in Chojnacki, 2010, p. 75).

Midwifery models of care will continue to play an important role in childbearing women worldwide when choosing to remain in control of their own bodies' capabilities or to simply have a choice. To what extent these models are advocated will greatly depend on individual governments, their change in policies, and financial support.

Chojnacki (2010) concludes women choose their birthing options based on their spiritual, religious, political and feminist beliefs. Misunderstandings will remain between lawmakers, physicians, and women as the importance of such opinions is trivialized (Cohen, as cited in Chojnacki, 2010, p. 51).

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