# The midwife: promoting normality in childbirth

The aim of this essay is to discuss how the midwife is ‘ the expert of normal’ and how she may promote normality in childbirth.

The author will define ‘ the midwife as the expert of the normal’. However, it may be impossible to accurately define as these differ between disciplines, organisations and individuals. However, the author will also define the concept of normal as it is an important factor in determining normality in childbirth.

The author will focus on the role of the midwife in promoting normality also analysing ‘ Woman Centred Care’ and how the principals may have a beneficial impact on the outcomes of care in the context of normality in childbirth.

Finally the author will discuss the findings in detail using relevant literature and resources and make recommendations for future midwifery practice.

Midwives are expert professionals skilled in supporting and maximising normal birth and these midwifery skills need to be promoted and valued. The role of the midwife is integral to models of care, which promote normality. Maternity Services can enhance midwifery skills and autonomous practice by providing appropriate practice settings RCM (2000).

The author agrees that midwives are experts in normal. The underpinning for her practice is facilitating uncomplicated pregnancies and labour with successful delivery of a fetus with unnecessary medical interventions. The author questions what normal/normality in the context of childbirth. The author is of the opinion that the concept of normal is that health is a natural

or usual a process. Childbirth is also a natural course of action, which focuses on natural responses of the woman’s body that constitutes suitability for giving birth. An exploration of the word normal suggests something usual, accepted as being the same, conforming to a standard Gould (2000). However in the context of midwifery, normality and childbirth need to explored as a whole concept so that a specific definition is agreed upon and accepted by all in midwifery practice Brown (1993).

The midwife is an expert in normal childbirth she assists the woman in her natural process and in promoting normal birth assists in the normal physiological process of labour and birth. She is an educator, communicator and a clinician and a practitioner of normal. Offers support, protects the woman and empowers as she works autonomously in uncomplicated pregnancies that require no medical interventions. In order for her to achieve this qualification she would have spent several years of training on a recognised degree program. This would require her to demonstrate proficiency in providing midwifery care to women in line with all statutory guidelines. Illustrating sound knowledge, skills and capability to practice and provide midwifery care. (‘ Standards of Proficiency for Pre-Registration Midwifery Education’ (NMC 2004a). As a qualified midwife she is expected to have an understanding of key policy directives which are relevant that influence her practice, develop and reflect on her interactions using critical analysis and research to facilitate the planning and delivery of midwifery care (REF THIS)

The role midwife is very diverse as she provides health and parent education, gives support to the mother and family throughout the

childbearing process and helps them adjust into parenthood. She also works in partnership with various multidisciplinary teams and health professionals in order to meet the needs and challenges of women from a variety of social and diverse backgrounds. This is supported in various published guidelines and legislations that define the midwife's role and scope of practice which are all relevant to the midwife in promoting normality in childbirth (RCM 2004). In order to facilitate care given should be tailored towards the specific needs of the pregnant woman and the family. This involves examining the woman holistically taking into account the emotional, psychological, and social aspects of her pregnancy and childbirth thus carrying out full clinical assessment offering support and advice when appropriate (Robinson, 1989) When the midwife undertakes any such activity she is using her skills and knowledge and draws upon her nursing theories, which enables her to reduce the needs and solve the problem. In the case of the community setting a primagravida of 19 weeks gestation presents with upper oesophageal reflux, which is a minor disorder in pregnancy. Research suggests that as the fundus expands discomfort can be felt and is a common occurrence in pregnancy. Certain foods can exacerbate the condition. Advice given to avoid spicy foods, wear loose clothing or use extra pillows for support. However medication can be sort to reduce the symptoms. The advice helped to reduce the woman's anxiety. The midwife was able to draw upon her practical nursing theories using reflection combined with her experience and knowledge. Agyris and Schon (1974).

As the primary carer the midwife is involved in the first stage which is the booking in process. Research suggests that creating a relaxing environment

is the key to promoting normality in midwifery care (Page & Percival 2000). In order to promote normality in childbirth the midwife needs to be in an environment that is conducive this may well be in the clients home or birth centre with an emphasis of normality. Therefore it should be as homely as possible. However within a birth centre this can be difficult as it is still a medical environment with equipment visible on the other hand is quite institutionalised with routines that lack privacy, this can contribute to the woman feeling out of control (Steele 1995). Therefore, it is best carried out in the woman's home away from hospital environment, as the woman is more likely to feel at ease and in control and empowered to discuss aspects of her personal life and plans for her antenatal and postnatal care. It is also important that the midwife gains the trust of the woman and involves her in the process placing her at the centre. Care should be individualised according to specific clinical needs of the woman, and her personal choices/preferences (DOH 1993). This can only be achieved when both the midwife and the woman have a common purpose with specific goals and targets allowing the woman to be empowered in her own right. The woman has knowledge and experience about herself which will help the midwife to actively participate in her care.

Another aspect of the midwifes role involves her being up to date with the current guidelines, evidence base and training to a standard which underpins midwifery practice. This will enable her to offer and deliver high quality care, safety and effectiveness. However, this whole concept was highlighted by Chochrane (1972) who noted discrepancies in medical care and decisions. This was rectified by the introduction of new resources for practitioners in

order to evaluate their skills and inform their practice. (Sackett et al 1996) suggests that evidence should facilitate evidence based practice and has been defined as: The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. To date, researchers are constantly carrying out detailed studies and reviews with published outcomes available for comparison. Therefore, we must weigh up what is beneficial and not harmful and use this to inform our practice.

It has been suggested that the role of the midwife has evolved in a number of ways and is influenced by the organisational setting Barclay et al (1989). In the case of Midwife led Units in the context of normality the author is of the opinion that the unit offers continuity of care and is more beneficial to the pregnant woman given the fact that the philosophy of care is based on promoting normality. The model currently in use in the current placement places an emphasis on team care approach with a specific named midwife assigned to a woman ultimately resulting in continuity of care. In other words midwives working in units that are midwife led provide care that is perceived to be more highly satisfactory NHS Management Executive, (1993). Furthermore, The Royal College of Midwives have clearly stated in their campaign for normal birth the importance of clear policies, philosophies of care and guidelines in order to support those involved in providing maternity care and services to facilitate normality in child birth. (RCM 2005).

Woman centred care is the philosophy which underpins midwifery practice today. It was derived from ‘ The Vision’ (Association of Radical Midwives (ARM 1986) and was included in the ‘ Changing Childbirth Report’ Department of Health (DOH 1993). “ The woman must be the focus of

maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved."(DOH, 1993),

The documents set about a change for maternity services. The ' Vision' listed several fundamental areas such as continuity of care, informed choice accountability and nonmaleficence. Caroline Flint 1992 suggested the importance of being able to create a knowing and trusting relationship with the woman is also important as this enables the relationship with the woman to develop. It is one of her key points for improving continuity in a midwife's role. Therefore, in order for the midwife to provide maternity care she needs to get to know the woman first and have regular contact. With this notion a study was carried out by McCourt et al 2006 on women who had consistently seen a particular midwife on a one-to-one basis, the study outlined that the women felt their needs were being met. On the other hand this model of care can lead to even higher expectations from women when the care varies in their opinion or when regular contact with the midwife is not maintained. It can be argued that we still maintain adequate levels of continuity in midwifery care as this can be provided by the multidisciplinary team and other health departments, furthermore, is dependent on the woman's particular need and circumstances. In contrast, we may question the quality/quantity and how this is perceived.

The midwife carries a caseload in the author's present community placement and this consists of women who come from affluent to less affluent areas. Those women who live in the affluent areas appeared to be educated to a

higher standard. They have clear expectations and appear to demand more in the way of in depth information from midwifery services. In contrast, the women from the lower social economic class gave the impression or lacked the skills in making decisions about their care but were happy to be directed by the midwife. They made no specific demands they seemed happy with the outcomes of their appointments. This implies that women's social economic class can have an effect on their health and status. However, women who are less educated or lack opportunity often lack decision making, in any event this consequently affects the woman's health status. (Norsigian et al 2005)

In 1993 the NHS reviewed its policy on maternity services and published ' Changing Childbirth'. A survey was carried out in 1996 by the Centre for Health Studies on ' Quality of Care and the availability of Support and Advice'. Questionnaires were sent to pregnant women on who should carry out their care, what they would want, when services should be made available, the type of location, what should they be seeking to provide, from maternity services in the future. The survey was posted to women between the ages of 21 to 40. The results of this survey showed the need for women to at the centre of care being involved in the decision making process, choice with regards to place to deliver and type of care given and continuity of care having regular contact with the midwife through pregnancy culminating in delivery. Whilst this type of research was qualitative the main aim was to understand pregnant woman's feelings, views and attitudes. This data was collected and highlighted their experiences within maternity services. The information was clearly sought and analysed. The questions

were targeted to a specific group and left no room for any other interpretation. Moreover, the participants were not conclusive as the data was limited to a specific age group and type it did not include those planning to have a baby. In conclusion the responses from the questionnaire suggests the need for flexibility and consideration of womens experiences and identifies the need for women to be at the centre offering advise choice, continuity and direct involvement in the delivery or creation of new service improvements in maternity care.