FIRST ANTENATAL VISIT: MEETING NOW FOR THE FUTURE

A GROUNDED THEORY STUDY OF THE MEETING BETWEEN THE INDEPENDENT MIDWIFE AND THE PREGNANT WOMAN

by

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ABSTRACT

This is a study of what happens between independent midwives and women at the first antenatal visit. Six experienced midwives and six pregnant women participated in the research. Data were gathered through the observation of six first antenatal visits, individual interviews with the women and midwives and a review of the literature. Grounded theory was used to conduct the study, and a descriptive model of the first antenatal visit emerged.

Up until the change to the Nurses Act in 1990 midwives predominately practiced within the hospital system. Since 1990 and the legalising of independent midwifery practice in New Zealand, midwives have taken up the challenge to practice independently. A few guidelines have been set to assist independent midwives in practice; some of the guidelines being used have been taken from the hospital system into independent practice.

The first antenatal visit is the beginning point of the relationship between the pregnant woman and the midwife. It is a key element for determining the quality and effectiveness of a mother's subsequent maternity care (Methven, 1990). The midwife and the woman each have an important part to play in the first antenatal visit which sets the stage for future care. The data from the study revealed a number of paradoxes that exist when independent midwives deliver midwifery-only care. The basic social process to emerge from the study was "meeting now for the future" but the study identified that the midwife and the woman are meeting for different reasons.

PREFACE

This study has been a long and exciting journey and has reinforced my position to see midwifery not from an illness perspective as I was taught but from a perspective of wellness. During my midwifery training in Edinburgh in 1974 I struggled with the medical model of practice. I did not feel comfortable with midwifery practice in the antenatal clinics where women were kept waiting for hours and had to travel long distances to the hospital, only to see a stranger. I disliked the antenatal clinic with its conveyor belt system and the midwife being the handmaiden to famous obstetricians. This was not good midwifery and I had yet to see it practiced.

Since coming to New Zealand in 1989 I have pursued study, completing an undergraduate degree and now this Masters degree. I have studied feminism and have learned to ask why.

In 1993 I witnessed my very first normal birth. This was the birth of a lovely little boy at home. He was brought into this world by his parents and supported by a midwife. This was a far cry from the clinical walls of the Edinburgh hospital and I loved it. This birth had a lasting effect on me and I was privileged to be part of it.

I have had to re-learn a lot about birthing. The language of normal birth is different from the language of obstetrics. I have moved from seeing pregnancy and birth as abnormal until proved otherwise, to seeing pregnancy and birth as a natural physiological event which occasionally may need medical intervention. New Zealand has given me a new perspective on birthing and I would like to give the findings of this research back to New Zealanders.

ACKNOWLEDGMENTS

It is with great pleasure that I acknowledge and thank those who have helped and supported me through this long and exciting journey of discovery. Although I am unable to mention everyone by name, I would still like to say thank-you to you all.

To the research participants I extend my heartfelt thanks. You volunteered to help me and without your contribution there would be no data. The midwives were enthusiastic and extremely helpful. When things did not go to plan with the data collection they came to my rescue and the research continued. The pregnant women were fun to work with and I hope they enjoyed participating as much as I did.

To my supervisors Dr. Cheryl Benn and Lesley Batten I am indebted. They were there when they were needed. They offered on-going encouragement, reassurance and kindness throughout the year. They were swift in answering my E-mails and always at the other end of the internet. They worked well as a team. I could not have wished for better research supervisors.

I must also thank those agencies that assisted me during my unpaid leave of absence to complete this research:

- Nursing Education and Research Foundation
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To my children, Paul and Lucy, I would like to thank them for their patience and tolerance during my years of study. I have missed many an outing and school event. I hope they understand. They supported me and hugged me when things got tough.

Finally I would like to thank the most important person in my life, my husband Andrew Sylvester. It was he who believed in me and supported me in this long journey. His contribution to this research is enormous and was never taken for granted. He never complained but quietly took over the major running of our family so many times. We worked well together and I look forward to returning the favour one day.

This is not the end but a continuation of my life-long learning. Thank you to all who helped.

CHAPTER 1

INTRODUCTION

INTRODUCTION

This grounded theory study aims to discover what is happening between the independent midwife[1] and the woman during the first antenatal visit. The motivation to explore this topic came from my study of advanced midwifery practice and my own experiences both as a midwife and a mother.

The medical model that has guided midwifery practice for many years has been well documented (Donley, 1986; Silverton, 1993; Tew, 1990). Up until 1990 the medical model of care was the only legal option available in New Zealand. From 1990 women have been able to choose a midwife to deliver their maternity care (Fleming, 1998).

Independent midwifery is a new concept and as a result New Zealand midwives are needing to define midwifery practice for themselves and the community they serve. To be able to do this it is essential that midwives carry out their own research to substantiate their practice, to continually improve practice, and to inform women of that practice.

Independent midwives in New Zealand have been very busy developing new ways of practicing and there has been little time available for them to undertake research. I decided therefore to start at the point where the midwife and the pregnant woman first come into physical contact with each other, that being the first antenatal visit.

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[1] An independent midwife in this study is a self employed midwife who is the lead maternity carer to the women under her care

KNOWLEDGE PRIOR TO THE STUDY

As a qualified midwife, a post graduate student of midwifery, a tutor and a mother, I bring to this research, knowledge and experience of aspects of midwifery. I have not practiced as an independent midwife but with my experience and knowledge of the literature on midwifery I was particularly interested in the development of midwifery since 1990.

My initial readings on midwifery, before deciding on the research question, were aimed at developing a greater understanding about the philosophy of midwifery practice. "The Vision" document (Association of Radical, 1986) helped clarify a midwifery philosophy for me. With a better understanding of philosophy I then looked critically at different models of midwifery. Guilliland and Pairman's (1995) partnership model and Lauchland's (1996) shared journey model was studied at this stage. Through the writings of Bannet (1993), Cheek and Rudge (1994), Kleffel (1991) and Stevens (1989) I gained a better understanding of critical social theory and its application to midwifery. Critical social theory allowed me to understand my philosophy better and raised my consciousness as a midwife in an environment where midwives and doctors had to work together in a hierarchical structure with doctors in a position of power. Skelton (1994) believes that before nurses (midwives) are in a position to empower clients they must empower themselves.

While trying to identify my area of study, I turned my attention to the literature on birthing at home. In the geographical region under study independent midwives are the only midwives to take part in homebirths although not all offer this service. Homebirth allows women to take control of their own birthing in partnership with a midwife. I developed

a better understanding of the common misbelief that hospital birth was the only safe option to homebirth. Davis-Floyd (1994, p.1125) stated "the dominant mythology of a culture is often displayed in the ritual with which it surrounds birth. In contemporary Western society, that mythology - the mythology of the technocracy - is enacted through obstetrical procedures." The work of Floyd (1995), Woodcock, Read, Bower, Stanley and Moore, (1994) and Thompson (1987) did not uphold the myth that hospital birth was the safest option, leaving me wondering if home may be safer than hospital birth for some women. Tew (1990, p.289) stated;

> When the history is told, it becomes very clear that at no time in the past or present and in no country have medical interventions made childbirth safer for most mothers and babies. No evidence can be found to support theories that, in general, applying the methods of physical science can evolve obstetric procedures which improve the natural birth process.

With this background in reading directing my thoughts, I decided I was initially interested in the antenatal experience between the independent midwife and the pregnant woman and the possible effects of a midwifery philosophy on practice. I decided not to look at birthing in the home as this took up only a small part of the independent midwife's job. As there was little New Zealand research into independent midwifery I decided that it was logical to begin at the starting point so I read literature on antenatal care.

ANTENATAL CARE

Antenatal care is a 20th century phenomenon. One of the aims of antenatal care is to ensure that women reach the end of the pregnancy

"emotionally prepared for delivery" (Bennett & Brown, 1989, p.119). Ballantyne anticipated that through antenatal care practitioners would be able to detect signs of abnormality in pregnancy that would consequently reduce complications in labour (Tew, 1990). In 1929 the British Ministry of Health in a Memorandum on Antenatal Clinics set a basic arbitrary pattern for all antenatal clinics that is followed today in many clinics throughout the world (Liu, Jevons, & Thwaites, 1992; Tew, 1990). It was this pattern that shaped New Zealand antenatal care. Although antenatal care has not been shown to prevent many life-threatening conditions (Hall, 1981) it has many benefits for women, babies and families including the education and information that can be exchanged (Benn, 1994).

The first antenatal visit is the first time a pregnant woman is seen by a health professional, be it midwife, GP or obstetrician to discuss maternity care during her pregnancy. This visit has been known by some as the "booking" visit. This term referred to women coming to the antenatal clinic to be sure of "booking" a hospital bed for the birth of their baby (Methven, 1990). Fawdry and Mutch (1986) contend that the recording of antenatal history is a relatively standard procedure at the first antenatal visit. Midwives see the interaction between mother and midwife as the first step in initiating a special relationship (Walker, 1976).

Williamson and Thomson's (1996) descriptive survey highlighted factors that caused dissatisfaction with antenatal care. The factors identified included a lack of continuity of care, poor quality of advice and extended waiting times. Thorley, Rouse and Campbell (1997) in a non randomised comparison study developed a new system of antenatal care in partnership with mothers. The basis of the new system is the meeting of mothers and professionals which provides education and support.

The preliminary results look encouraging, showing an increase in normal births and breast feeding with a low caesarian section rate.

There is an abundance of literature available on different aspects of antenatal care. In Battersby and Thomson's (1997) English study using a brief questionnaire and semi-structured interviews they found that the midwife, working at the general practitioner's (GP) surgery, was the professional undertaking the most antenatal care. In most instances there was a GP available on site if required. Whilst it was recognised that midwives were taking increasing responsibility for antenatal care, GPs still believed that the overall responsibility for maternity care lay with them. The findings of this study suggest that the midwife-led care could be an area that would provoke conflict between midwives and GPs. Midwives felt it was imperative that they become the first point of contact for the majority of women in order for the women to make informed choices on who should provide care. It was hoped that a better quality of advice be made available to women.

Turnbull (1984) surveyed, by means of a questionnaire, women attending an antenatal clinic in Australia. This study was initiated because waiting times in the antenatal clinic were perceived by midwives as being too long. Midwives were dissatisfied with their minimal contact with women and with primarily performing tasks such as urine testing, weighing women and taking blood pressures instead of educating women regarding their pregnancy. It was found that very little information was given to woman from the midwife and it was recommended that midwife-only clinics be commenced in place of some routine medical consultation. Turnbull also noted that reports from Western countries indicated a growing dissatisfaction with care being offered during the antenatal period.

Some authors questioned how many antenatal visits were required to provide an appropriate level of antenatal care (Chamberlin, 1978; Hall, 1981; MacLennan, 1986; Young, 1990). As well MacLennan (1986) examined and questioned the value of specific routine practices, for example urine testing.

Literature on barriers to antenatal care included personal factors affecting antenatal care up-take (Hansell, 1991), lack of education and ability to participate in self-care (McClanahan, 1992), socio-economic factors affecting the quality of antenatal care (Fardell, 1989) and much more. None of the literature addressed antenatal care in the home with the midwife taking full responsibility for care, nor was there any literature discussing the topic of antenatal visits involving independent midwives.

With this understanding of my background, which is important in a grounded theory study, and these beliefs I commenced the study. All reading on the subject was temporarily abandoned and no formal literature review was undertaken as I tried to adhere to the grounded theory method as described in the methodology chapter.

MIDWIFERY IN NEW ZEALAND

To understand independent midwifery today it is important to understand the history of yesterday. The past affects the present which in turn affects the future. It was the events of the past that culminated in the passing of the Nurses Amendment Act (1990). The Midwives Act of 1904 provided for the training and registration of autonomous midwives. Pregnancy was seen as a normal part of life needing little medical intervention. During the twentieth century there has been a

gradual erosion of midwives' autonomy due to the political strength of obstetricians and the accompanying use of technology (Kirkham, 1986).

The medicalisation of childbirth and antenatal care proved to be the major theme in the development of New Zealand obstetrics between the two world wars and there was a deep conviction within the ranks of the medical profession that doctors should assert their claim to be the moral guardians of motherhood (Mein Smith, 1986). Obstetrics became increasingly fashionable among doctors and obstetricians gained political power. The opportunity for midwives to practice midwifery autonomously declined as doctors became the preferred practitioner to screen pregnant women.

> It could be argued that it was with the development of antenatal care as a mass screening programme that midwifery as an autonomous profession began a long period of deterioration (Oakley, 1982, p.9).

This decline saw autonomous midwifery practice eroded with midwives being dependent on doctors (Fleming, 1994). More midwives practiced under the control of a doctor as more births were taking place in hospitals. Papps and Olssen (1997, p.74) put it thus:

> The rise of the hospital must be viewed as inextricably related to broader changes in social structure. In that their establishment marked the consolidation of medical management, they also fundamentally shifted childbirth from a process that was managed and controlled in the local community to a process that was controlled by an emergent professional group.

The shift from the community to hospital raised little concern among many midwives. Little fuss was made by midwives when the change to

the Nurses Act came in 1971. This amendment legally ended the autonomous practice of midwives and required that all births be supervised by a doctor. From 1971 midwifery practice in New Zealand continued to be overwhelmingly controlled by the medical profession (Donley, 1986).

There was a further reduction in the scope of midwifery practice with the Amendment to the Nurses Act in 1983. This amendment prohibited midwives who were not also registered nurses from attending births in "any place other than an institution under the control of an Area Health Board or Hospital Board" (Nurses Amendment Act, 1983, p.10). Fleming (1994) also believes that the 1983 Act impacted on midwives who practiced in hospitals in that there was no differentiation made between nurses and midwives. Midwives had therefore become all but invisible, being incorporated under the broader category of nurses. By the 1980s various reports, legislation and the relocation of midwifery education into Advanced Diploma of Nursing courses put midwives, as a professional group, in a very vulnerable position (Fleming, 1994).

This vulnerable situation meant that the care of a pregnant woman was controlled by doctors. In Britain it was the GP that acted as the gatekeeper controlling access to maternity care (Silverton, 1993). This was the case in New Zealand and still is, in some places where the GP, for many women, is still the first point of contact. Nearly all antenatal visits were conducted in a hospital or GP setting. Midwives were able to assist the doctor and practice under the auspices of the doctor but they could not take responsibility for the full care of a pregnant woman. Many midwives were silent about the changes to their profession but there was enough activity that would allow midwifery to regain its autonomy.

Consumers and Midwives

To ensure the continuation of the midwifery profession and provide safe midwifery-only care to women, midwives had to challenge the medicalisation of childbirth. The Homebirth Association founded in Auckland in 1978 by consumers and midwives took up this challenge. By 1979 there were four domiciliary midwives (midwives who attended homebirths) in Auckland. Donley (1992) provides a detailed history of the homebirth movement that fought to preserve women's rights to choose their place of birth. Fleming (1994) believed the aim of the homebirth movement was to raise awareness of the options of birthing at home to potential consumers and their attendants. It is important to note that one of the major successes of the Homebirth Association in New Zealand was its bringing together of midwives and consumers to work towards a common goal. This relationship between consumers and midwives had a huge influence on the future direction of midwifery and women's choices.

Consumers and midwives were also working together in the Save the Midwives Association in their political struggle against the Nurses Amendment Act of 1983. The Association wanted to rebel against the medical and nursing domination of midwifery and develop a direct entry midwifery education programme. The Save the Midwives Association "served to unite hospital and domiciliary midwives" (Fleming, 1994, p.16). Members of the Association became politically active and worked hard at lobbying women's groups who in turn lobbied Members of Parliament (Fleming, 1994). Other groups involved in assisting midwives to achieve independence included such groups as Parent Centre and the Domiciliary Midwives' Society (Donley, 1986).

Although a Midwives' Special Interest Section within the New Zealand Nurses Association (NZNA) was begun in 1972 the relationship with

NZNA was often strained. NZNA believed that a midwife was a nurse (NZNA, 1981) which was not supported by the World Health Organisation (1966) definition (see Appendix I) or the International Council of Midwives. Donley (1986) believes the incorporation of midwives into the Nurses' Association strengthened the nursing profession at the same time as weakening the midwifery profession.

With consumer discontent, political unrest among midwives and differences between NZNA and the Midwives Special Interest Group the time was right for change (Papps & Olssen, 1997). In 1988 at the National Midwives' Conference the New Zealand College of Midwives (NZCOM) was officially launched. Membership of the College was open to both consumers and midwives thus cementing their relationship that had been developing over the last 20 years. Consumers and midwives were now officially working in partnership within the NZCOM (Fleming, 1994).

The NZCOM's main task was to continue the struggle towards the reinstatement of autonomous midwifery practice through a change to the 1977 Nurses Act. Finally, in August 1990 the long awaited change occurred. Midwives no longer needed double registration as a nurse and a midwife and did not need to be supervised by a doctor. A new era of midwifery had begun which would give women more choice in the kind of care that could be obtained during pregnancy, birth and the post natal period.

Independent Midwifery

As a practicing midwife in 1990 I was aware that this new era of midwifery took some midwives by surprise and many midwives, who mainly practiced in hospitals, were unprepared for independent

practice. A few midwives did take up the challenge to practice independently and as a result of vigorous negotiations by the NZCOM, midwives achieved pay equity with medical practitioners. The amendment to the Act also included limited prescribing rights for midwives and so there was now no need for a doctor to be involved unless a problem was detected. Midwives could now care for women throughout pregnancy, labour, birth and the post natal period providing midwifery-only care. Independent midwives had to obtain hospital admitting privileges from their then local Crown Health Enterprises (CHEs) so that women had the choice of giving birth, supported by an independent midwife, at home or in a hospital.

Forms of Midwifery in NZ

Midwifery practice can be divided into two specific groups: those midwives who practice independent midwifery care and those midwives who work under the direction of a doctor and generally work in hospitals. Independent midwifery practitioners provide full maternity care in a variety of settings to women during normal pregnancy, birth and the post natal period without the support of a doctor. These midwives can prescribe the necessary tests and medication for pregnancy related conditions and refer women to obstetricians if the need arises.

Midwifery-only care can be provided by a group of midwives working in teams, or by individual midwives taking on their own caseloads (Flint, 1993). The team midwifery approach means that pregnant women meet all the midwives in the team during the antenatal period. When the woman goes into labour it is a known midwife on call who will provide the necessary care (Calvert, 1998). The size of teams can vary considerably but can have five or six midwives to a team (Flint, 1993;

Seccombe & Stock, 1995). Guilliland and Pairman (1994, p. 9), on looking at the size of these teams, state that "for continuity of caregiver to be a reality for both the woman and the midwife, the teams must be no greater than three".

In the caseload approach, the pregnant woman has a specific midwife who will take full responsibility for providing the necessary maternity services. She will provide continuity of care and be the lead maternity carer (LMC)[2]. Midwives in the caseload model may have a loose relationship with other midwives where reciprocal cover is arranged during leave and sickness periods. This is described by Guilliland and Pairman (1994, p.8) as a "backup colleague". It is this form of practice that is the focus of this study as only the caseload model of practice is being offered in the area where the research was undertaken.

Shared care is another option that may occasionally be available to women. This involves the pregnant woman having her prenatal care shared between a midwife and a doctor (Fleming, 1994). In the past both practitioners were able to claim separate fees for this arrangement but this is no longer a possibility. Maternity care is now bulk funded and financial arrangements are worked out between the doctor and the midwife (Guilliland, 1998, personal communication).

Hospital based midwifery care is still available in New Zealand. Care is provided by the midwives on duty at the time and prior to labour the pregnant woman has no way of knowing who, or how many midwives, will look after her. In this situation a women is cared for by a number of different midwives throughout her pregnancy, childbirth and post natal period. It is also possible that the women in hospital may be looked after by enrolled nurses or registered nurses. Independent midwives are not involved in providing this type of care. Know Your Midwife (KYM)

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[2] LMC is the General Practitioner, Midwife or Obstetric Specialist who has been selected by the woman to provide her comprehensive maternity care including the management of her labour and birth

schemes and team midwifery are also available within the hospital system but do not involve independent self employed midwives.

Midwives working in the various settings described will have been influenced by models of midwifery. The models presented are New Zealand models and are described as either a partnership, a shared journey or a shared interdependence between the midwife and the pregnant woman.

A Partnership Model of Midwifery Practice

The model of midwifery practice likely to have had the most impact on New Zealand midwives is the partnership model of midwifery practice. At a midwives conference in 1996, Sally Pairman the president of the NZCOM stated "as you are all aware the concept of partnership underpins New Zealand midwifery" (Pairman, 1996, p. 2). This partnership model fits comfortably with the bi-cultural nature of New Zealand society and with the Treaty of Waitangi. This Treaty was signed in 1840 between Maori and the Crown incorporating the principles of partnership, participation, protection and equity (Ramsden, 1990). It also fits comfortably with the philosophy of the NZCOM (1993, p. 7) which states "that midwifery care takes place in partnership with women".

The philosophical beliefs underpinning the partnership developed by Guilliland and Pairman (1995) are that midwifery practice should be woman-centred, that pregnancy and birth be seen as normal life events, that midwives have professional independence and that continuity of midwifery care be provided. "This partnership therefore, is an ethical stance and a standard for practice" (Guilliland & Pairman, 1995, p.8). These authors believe that the successful establishment and

maintenance of the midwifery partnership is dependent on the integration in the relationship between the midwife and the pregnant woman of the following concepts:

- Individual negotiation
- Equality, shared responsibility and empowerment
- Informed choice and consent (p.44)

A Shared journey

Lauchland (1996, p.26) believes that "more questions surround partnership in clinical practice than have been answered". Giving her own personal view on the process and context of midwifery care, Lauchland sees it as being a shared journey between woman and midwife but acknowledges that research into partnership is in its infancy.

Interdependence

The major component of Fleming's (1996a) model of midwifery is interdependence between the midwife and the woman. She describes the relationship between the midwife and woman as unique when compared with the relationship between the doctor and the woman. Fleming identifies many social, cultural and environmental factors which include education, friends and her own personal beliefs that may be invisible but may influence the relationship between the woman and the midwife. Fleming (1996, p.4) describes these factors as being "invisible in the final product but nevertheless bind it together". An analogy of homespun wool was used to describe the intricate nature of the midwifery relationship. Fleming believes her model will remain incomplete due to the constant changes that affect women.

For midwives to work as self employed independent practitioners they are required to register as the Lead Maternity Carer (LMC). This was introduced in 1996 by the Regional Health Authorities and affected midwives, GPs and obstetricians (Midland Regional Health Authority, 1996).

SUMMARY

This chapter serves as an introduction to this study that aims to explore what happens at the first antenatal visit as undertaken by an independent midwife. The reader is informed of my background before commencing the study and the literature that led to the development of the research question. The development of antenatal care has been discussed and the benefits of it have been given. The history of midwifery in New Zealand gives the reader an understanding of the development of midwifery that culminated in the change to the Nurses Act in 1990 and prompted this research. In conclusion an overview of the structure of this thesis is presented.

CHAPTER CONTENT AND OVERVIEW

Chapter 2: Research Methodology

In this chapter the research methodology of grounded theory and its links with symbolic interactionism are explored. The research process is discussed, with a focus on its special applicability to midwifery studies. The application of the methodology to the present study is documented.

Chapter 3: Setting The Stage

Chapter three is the first of four data chapters. The role of the midwife in the first antenatal visit is explored. It describes the process of "setting of the stage" by the midwife.

Chapter 4: The Paradoxes

This chapter looks at the paradoxes that exist for midwives when trying to deliver independent midwifery only services.

Chapter 5: Getting to Know My Midwife

The experiences of the women at the first antenatal visit are explored. This involves confirmation of the pregnancy and seeking out midwifery only care. A discussion of what women require during the first visit is provided.

Chapter 6: Meeting Now For the Future

The integrated descriptive model which encapsulates both midwives' and women's perspectives of the first antenatal visit is presented. An audit trail of the researcher's decisions during data analysis concludes this chapter.

Chapter 7: Discussion and Recommendation

A discussion of the implications of this research for midwifery practice is provided. Recommendations for education and some specific limitations of this study are addressed. The chapter ends with suggestions for future research.

CHAPTER 2

METHODOLOGY

INTRODUCTION

This qualitative study uses grounded theory to discover what happens between the woman and the independent midwife at the first antenatal visit. In this chapter I will examine grounded theory methodology and provide an overview of symbolic interactionism. An application of the methodology in this study will be discussed in detail along with a discussion of the ethical issues and the process of obtaining informed consent.

GROUNDED THEORY DEVELOPMENT AND THEORISTS

Grounded theory was developed by Glaser and Strauss in the mid-1960s. Glaser was schooled in the Colombian philosophy of quantitative analysis. Strauss was an ethnographer from the Chicago School where he was exposed to the perspective of symbolic interactionism. Symbolic interactionism means that grounded theory "is more than just a method of data analysis; it is an entire philosophy about how to conduct research" (Polit & Hungler, 1989, p.324).

It was George Herbert Mead who laid the foundations of the symbolic interactionist approach that explores how people define reality and how their beliefs are related to reality (Blumer, 1969). Within this perspective reality is created by people who attach meaning to situations - meaning is expressed in terms of symbols such as words, religious objects, and clothing. In social life, shared meanings are communicated to new

members through socialisation processes. Interaction may lead to new meanings and can result in the redefinition of self. The symbolic interactionist approach is based on three premises articulated by Blumer who stated (1969, p. 2):

> Human beings act towards things based on the meanings that the things have for them; the meaning of such things is derived from the social interaction that the individual has with his fellows; and the meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter.

The symbolic interactionist studies behaviour on two levels, an interactional level and a symbolic level. Because of its theoretical importance, the interaction is the focus of observation in grounded theory research (Chenitz & Swanson, 1986).

Glaser and Strauss worked together to develop a methodology that was qualitative in nature, yet retained the rigour of the Colombian School (Keddy, Sims, & Stern, 1996). Glaser and Strauss (1967) wrote *The Discovery of Grounded Theory,* which outlined the new research methodology. Subsequently it has been further developed by its originators and their students (Glaser, 1992; Stern, 1980; Strauss & Corbin, 1990). The ideas of Glaser and Strauss diverged in the 1980s. In 1992 Glaser wrote a book in response to Strauss and Corbin's (1990) *Basics of Qualitative Research,* criticising the authors for distorting the procedures and meaning of grounded theory (Holloway & Wheeler, 1996). In recent years Glaser and Strauss developed differing viewpoints on how data gathered for grounded theory research should be examined (Glaser, 1992; Strauss & Corbin, 1990). The researcher needs to be aware of these differences.

Grounded theory provides a process for investigating previously unresearched areas, to gain a fresh perspective on a familiar situation (Stern, 1980). Grounded theory's systematic techniques and procedures of analysis enables the researcher to develop a substantive theory that meets the requirements of scientific research: significance, theory observation, compatibility, generalisability, reproducability, precision, rigour and verification (Strauss & Corbin, 1990). Grounded theory research can be used as a precursor to further investigation (Chenitz & Swanson, 1986).

The purpose of grounded theory research is to explain a given social situation by identifying the core and subsidiary processes operating in it. The focus is on the things people say about the way they are doing things (Wiener & Wysman, 1990) and observations on what they are doing. Grounded theory offers a systematic method to collect, organise and analyse data from the empirical world. It is an approach to theory development based on the study of human conduct and the context and forces that impinge on human conduct (Chenitz & Swanson, 1986; Wiener & Wysman, 1990). To study human conduct grounded theory researchers require a specific type of question.

GROUNDED THEORY RESEARCH QUESTION

The research question in a grounded theory study is a statement that identifies the phenomenon to be studied and tends to be orientated towards action and process (Strauss & Corbin, 1990). The research question is used to focus the research so that patterns in the problem can be identified (Chenitz & Swanson, 1986). Christensen (1990) undertook a grounded theory study of nursing in action in an attempt to discover the phenomenon that was within the domain of the nursing

in a surgical ward while the patient was undergoing planned surgery. She asked the question "What is happening here?" focussing her interest on the patterning of the encounter between nurse and patient. My research question attempts to discover what is happening between the midwife and the woman at the first antenatal visit.

USE OF LITERATURE IN A GROUNDED THEORY STUDY

An extensive literature review is seen as an important part of many research studies. In a grounded theory study, literature is not extensively searched at the beginning, as the researcher could unconsciously fall into accepting what is written (Chenitz & Swanson, 1986). "When the theory seems sufficiently grounded and developed, *then* we review the literature in the field and relate the theory to it through integration of ideas" (Glaser, 1978, p. 31). According to Chenitz and Swanson reviewing the literature is seen as an ongoing process that is conducted to fulfill the needs of the analysis. The literature used is determined by the codes that emerge during data analysis and as a data source help to enrich the developing theory. A final literature review is conducted at the end of the analysis and the theory is presented in the context of other work and existing theories on the subject (Marcus & Liehr, 1998).

In the present study it was decided not to include a review of the literature. Glaser (1992) believes there is no need to review any of the literature in the substantive area under study. It was decided to follow Glaser's (1992, p.32) advice when he wrote:

> Grounded theory is for the discovery of concepts and hypotheses, not for testing or replicating them. Thus the license and mandate of grounded theory is to be free to discover in every way possible.

> It must be free from the claims of related literature and its findings and assumptions in order to render the data conceptually with the best fit. Grounded theory must be free from the idea of working on someone else's work or problem. However this stance is part of the methodology only in the beginning.

I started to review and integrate the literature into the analysis once the categories and the core category began to emerge, continuing until the final draft.

THE RESEARCHER AS AN INSTRUMENT

The researcher who is looking at answering a grounded theory question will conduct research in the field (Wells, 1995; Wiener & Wysman, 1990). If working and undertaking research in the field, the researcher needs to be able to interact with the participants. This interaction helps in gathering data from a range of sources including participants, diaries and other documents.

As the data are collected the researcher develops theoretical sensitivity (Glaser & Strauss, 1967) which is paramount to the research process (Strauss & Corbin, 1990). "Theoretical sensitivity refers to the attitude of having insight, the ability to give meaning to data, the capacity to understand and capability to separate the pertinent from that which is not" (Strauss & Corbin, 1990, p. 42). Glaser (1978) believes the first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible so that the researcher can remain open to what is happening. Sensitivity is increased by being steeped in the literature that deals with both the kinds of variables and their associated general ideas that will be used once the core category is identified.

PARTICIPANTS IN GROUNDED THEORY

In a grounded theory study the participants are those who have experience of the phenomenon under study. Twelve participants, of which, six were self employed independent midwives and six pregnant women, were recruited. The criteria for acceptance were that the midwives had to be self employed independent midwives, and the women had to be pregnant and going to their first antenatal visit. Another criterion was that all participants were fluent in English.

DATA ANALYSIS

The researcher begins to analyse and interpret the data as soon as collected, attentive to the aim of building a theoretical analysis. The researcher will be collecting data, writing memos, writing field notes, organising data, and forming theory from the data all at the same time The interviews are analysed line-by-line with the research question "what is going on here" to guide the process. The data analysis is looking for patterns, processes and one or more central themes which would then lead to the development of a theory. The analysis of the data is done by "an analytic procedure of constant comparison" (Glaser & Strauss, 1967, p.102). The four stages of the constant comparative method involve: "(1) comparing incidents applicable to each category; (2) integration of categories and their properties, (3) delimitation of the theory and (4) writing the theory" (Glaser & Strauss, 1967, p.105). Holloway and Wheeler (1996) explain that the researcher compares each section of the data with every other throughout the study for similarities and differences

Constant comparative analysis can be used to generate two basic types of middle-range theories. These can be either substantive theories, developed from empirical substantive inquiry or formal theories from research into conceptual areas of interest (Glaser & Strauss, 1967). There is a risk of an error being made when a researcher thinks they can make a leap from substantive to formal theory. This cannot be done with any assurance unless there has been further research (Strauss & Corbin, 1990). Glaser (1978) believes that formal theory cannot fit or work very well when written from only one substantive area because it cannot be developed sufficiently to take into account many of the contingencies and qualifications that will be met in the diverse substantive areas to which it will be applied.

Throughout the research process and the analysis of the data the researcher is an instrument and an active participant. The researcher is involved in choosing the question, analysing the data and selecting what next to ask of the participants. As an instrument the researcher decides what data to collect next and where those data could be found. This is known as theoretical sampling. Glaser (1992, p.101) defines theoretical sampling as "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges".

As an instrument in the research process the researcher needs inductive and deductive reasoning skills. Inductive reasoning is a process in which the researcher starts with observation and facts and moves towards generalisations. Deductive reasoning occurs when logical thought moves from theory to fact by means of propositions stated as hypotheses (Seaman, 1987). Grounded theory research moves from an inductive to a deductive mode. As part of grounded theory research hypotheses may develop either from data or the literature or a

combination of the two and these are then tested for verification (Stern, 1980). Grounded theory does not start with an hypothesis but after collecting the data relationships are established and provisional hypotheses are constructed (Holloway & Wheeler, 1996).

When provisional hypotheses are established the literature is examined to determine the "fit" of findings from earlier studies and of existing theory with present findings (Burns & Grove, 1993). As stated literature in a grounded theory study, unlike the case of traditional research, is not extensively searched at the beginning of the study as the researcher could unconsciously fall into accepting what is written (Chenitz & Swanson, 1986).

Data are collected until "saturation" is reached, where patterns are established and no more relevant differences are found among the dimensions of conditions, strategies and consequences (Chenitz & Swanson, 1986, p. 97). Rather than working in a linear fashion the researcher works within a matrix of data analysis, collecting and simultaneous report writing.

MEMOING

A strategy of memoing is utilised by the researcher throughout the whole research process (Glaser & Strauss, 1967). "Memoing is a method of preserving emerging hypotheses, analytical schemes and abstractions. At certain points when the data are being coded, an idea will strike, and if it is not recorded, the researcher will lose the thought" (Stern, 1980, p. 23). Memos are defined by Glaser (1978, p. 83) as "the theorising write -up of ideas about codes and their relationships as they strike the analyst while coding". Eventually memos become integrated in the writing. Glaser emphasised, at a lecture in New Zealand, the

importance of typing memos as soon as you get an idea and using the memos as the basis of writing (Pybus, 1996, p.49). Glaser's advice was to "get in, do the work, then publish" (Pybus, 1996, p.49).

CREDIBILITY

The publication of the research opens the research up to professional scrutiny and allows others to determine its credibility. Sandelowski (1986, p.30) defines credibility in a qualitative study as "such faithful description or interpretation of a human experience that the people having the experience would immediately recognise it from those descriptions or interpretations as their own".

The researcher should be explicit about important interpretations, and provide sufficient clear statements of theory description so that the reader can carefully assess the credibility of the theoretical framework being offered (Glaser & Strauss, 1967). A grounded theory must 'fit' the phenomenon under study, have 'grab' and 'work' when put to use (Glaser & Strauss, 1967). "Fit" means that the categories generated must be indicated by the data and applied readily to the data. "Grab" means that the theory speaks to or is relevant to the social or practice world and to the persons in that world. "Work" refers to the relevance or usefulness of the theory to explain, interpret and predict phenomena under study (Glaser & Strauss, 1967). The combination of all adds credibility to the theory.

THE METHODOLOGY EMPLOYED IN THIS STUDY

The application of grounded theory to this study is described below. It involves the recruitment of participants, data collection and analysis

and provides a detailed account of how ethical concerns were addressed.

Procedure for recruiting participants

Self employed independent midwives and pregnant women attending their first antenatal visit participated in this study. I attended a planned monthly meeting of the independent midwives working in the area and invited them to participate. Potential midwife participants were given an information sheet (Appendix D) and advised to contact the researcher if they wished to participate. On contacting me arrangements were made with the midwife to meet and discuss the study and to sign the consent form (Appendix F).

The midwives were asked to inform pregnant women of the study when an appointment was made for the first antenatal visit. A letter of introduction (Appendix B) was sent by the midwife to the woman informing her of the study. Pregnant women were invited to contact me to indicate their desire to participate in the study. An information sheet (Appendix C) was then sent to each woman and a meeting was arranged to discuss the research and arrange the signing of the consent form (Appendix E) if she was still prepared to participate. All the women who phoned me were happy to participate in this research.

Participants

The six participating midwives had all worked in a hospital setting before commencing work as independent practitioners. One midwife had been an independent midwife since relatively recently but the other midwives had become independent midwives over the last seven years

There were three first time mothers, two second time mothers and one third time mother. Of the three mothers who had been pregnant before, all had used the services of an independent midwife for their previous pregnancy's. At this early stage in their pregnancy only one woman was considering a home birth.

Data Collection

Data collected were by means of observing and audio-taping the first antenatal visit and then following up with individual audio-taped interviews conducted within a week of the first antenatal visit. The observations and interviews were performed between May and September 1998. The visits were between forty minutes and two hours long. The first antenatal visits were arranged between the midwife and the woman and I was invited to attend. I arranged the follow-up interviews at times and venues suitable for each participant, and very effort was made to minimise any inconvenience.

Six antenatal visits were observed and audio taped. I introduced myself then placed myself in the corner of the room to observe, take notes and audio-tape the first antenatal visit only answering questions if asked. By limiting the data collection to interviewing only without observing, I would have found it difficult to really grasp what was going on. Too often research, ironically, leaves out the human relationship element (Burnard, 1995).

To get a better understanding of the scene of the first antenatal visit it was important to observe and audio-tape the visit. This allowed the observation of a multiplicity of subtle gestures and non-verbal forms of communication. Burnard (, 1995, p.62) states that:

> Human communication occurs across a range of senses and is rarely, if ever, limited to the aural appreciation of the spoken words and the understanding of those words.

Handling the Data

Twenty-one taped interviews or first visits were undertaken (three participants were interviewed twice) yielding a large amount of data. The interviews were well spaced giving time to be able to think and write notes about the analysis. Rodgers and Cowles (1993, p224) found that it was possible that exhaustive data collection associated with qualitative studies could have an effect on the rigour of the study and more time between interviews was needed to "regroup". I found the time between the interviews allowed me to write my memos and undertake the constant comparative analysis required.

All information and material produced in the form of raw data were kept in the strictest of confidence. All audio tapes, notes and any other such material were stored in a locked and safe cabinet for the duration of the project and beyond. My supervisors, transcribers (I had three) and I were the only people with access to the research material. The transcribers each signed a confidentiality contract before any material was seen. Once the research is completed, the audio tapes will either be returned to the participants, if they so wish or be kept in a locked filing cabinet for five years.

Data Analysis

As soon as possible after the interviews the field notes were analysed. On receiving the transcription of each tape on a computer disc it was

initially scrutinised while listening to the audio-tape. Any unclear passages were corrected before printing the transcripts for analysis. The transcripts were analysed line by line using an open coding procedure. The research question "what is happening between the independent midwife and the woman at the first antenatal visit" was written on top of all the data and stuck onto the computer. This was a constant reminder to stay focussed on the question. Codes were developed from the words of the participants. As new data came in and new codes were developed, they were constantly compared and emerging categories were included or discarded where appropriate. Codes were arranged into groups and then into categories. No computer coding package was used. The computer was used to copy and paste data matching it with the developing categories.

Memoing

Theoretical memos were written at the same time as the data were being analysed. These memos helped shape the model and give direction on the line of questioning I needed to focus on next. Glaser and Strauss (1967, p.251) regard this process of thinking and reflecting on the data and the categories as important because "the root of sources of all significant theorising are the sensitive insights of the observer himself".

Saturation

When no new data appears to be emerging from the interviews and observation, theoretical saturation is said to have been reached. Due to the time frame of a Masters thesis it is difficult to state categorically that theoretical saturation has occurred. In this study after the twenty-

first taped encounter there appeared to be little new data emerging and so at this point it was decided to stop collecting data.

Ethical Concerns

Adhering to strict ethical guidelines and ensuring the safety and anonymity of participants in this research was of the utmost importance. At all times the rights of the participants were uppermost in my mind. Ethics approval was sought from three different ethics committees, namely Massey University Human Ethics Committee the local Health Funding Authority and the local polytechnic Ethics Committee. The ethical issues were addressed as follows:

Informed Consent

In compliance with the 'Code of Ethical Conduct for Researching and Teaching involving Human Subjects' (Massey University, 1994), all participants were fully informed verbally and in writing (Information Sheets, Appendix C & D) about the nature of the research and their likely involvement in the study. The women were informed that they had the right to withdraw from the research at any time and that this would in no way affect their care. The midwives were informed that they had a right to withdraw from the research at any time and that this would in no way affect their practice.

Anonymity and Confidentiality

The participants were assured that anonymity would be maintained at all times. Each participant either chose or was given a pseudonym that was known only to the researcher and the participant. Every effort was

made to suppress the identity of the participants by changing their real names to a pseudonym and omitting identifying details of places, institutions or any other persons. As the typist also had access to the raw data each person was assured that she had signed a confidentiality contract.

Potential Harm to Participants

Due to the nature of this research it was highly unlikely that participants would suffer any harm during this study. No situation arose where the researcher considered that the interview or observation was causing any undue stress to participants. On the contrary the midwives verbalised that simply participating in the research forced them to seriously consider their actions and improve their practice.

On interviewing a prospective participant I did feel at risk from the husband. I informed my supervisors and was advised not to recruit the woman into the study. This issue will be addressed in the final chapter.

SUMMARY

In this chapter a description of grounded theory methodology and its place in generating new knowledge for midwifery practice is provided. A portrayal of the use of grounded theory in this study is given, particularly addressing the issues of recruitment of participants and the important of adhering to strict ethical protocols. In chapter three the work of the midwife at the first antenatal visit is discussed with reference to the data collected.

INTRODUCTION TO THE DATA

The following conventions have been used within the data chapters and are presented here to assist the reader's interpretation

...	Pause
(...)	Material edited
1: 39	interview 1 starting line 39
(FAV)	First Antenatal Visit
Bold	Emphasis
Italics	participant's speech

As all the participants were women the pregnant women were identified by a name and the midwives were identified as "Midwife" followed by a name e.g. Midwife Jana.

CHAPTER 3

SETTING THE STAGE

I guess the main thing for me was (...) sort of just ***setting the stage*** *for setting things up for her antenatal care* (Midwife Cath, 1: 305).

INTRODUCTION

The midwife is presented first because it is the midwife who conducts the first antenatal visit and speaks the majority of the time. I have separated the information on the midwives and the women into separate chapters because the midwives and the women are meeting for different reasons. At the first antenatal visit the midwife is setting the stage for future care. During the visit the midwife gives information to the woman and obtains information from her. Throughout this encounter a relationship is beginning to develop and will continue to do so through the antenatal period, birth and the post natal period. Before addressing the issues raised above a description of the first antenatal visit will be given.

THE FIRST ANTENATAL VISIT

The first antenatal visit is the first of many meetings between the midwife and the pregnant woman during pregnancy, birth and the post natal period up to six weeks after the baby is born. It results after the pregnant woman has chosen to contact a midwife and after a brief discussion on the phone an appointment for the first antenatal visit is arranged. All the observed visits took place in a home environment,

either the pregnant woman's home, or in one case, in the midwife's home. The women contacted the midwives very early in their pregnancy and all first antenatal visits were arranged before the women were ten weeks pregnant.

Other adults such as the woman's partner, her mother or both were present during three of the visits. At two visits pre-school children were present. The children played with their toys or sat on their mother's knees.

The midwives were able to claim $25 for the first antenatal visit which lasted between forty minutes and two hours. The main activities of this first visit involved the giving of verbal and written information by the midwife, the filling out of the standardised antenatal notes (see appendix H) and the recording of baseline data. The data collected on the pregnant woman included blood pressure measurement, urine testing, checking of the heart and lungs and performing a brief abdominal palpation to check whether the uterus was palpable or not.

SETTING THE STAGE

The setting of the stage is one of the main categories to emerge from this study. The two main characters in this scene were the midwife and the pregnant woman but it is the midwife who sets the stage. The first antenatal visit is the first of many scenes culminating in the birth of the baby and the post natal period. This was described by one of the midwives, on visiting a woman in her second pregnancy, when she said that the first antenatal was about:

> *reminding her* (the pregnant woman) *how the relationship works and all that, like some of the things we talk about, it's like we have to set the stage for now and in the future* (Midwife Cath, 1: 200).

The setting of the stage involves the midwife making the scene informal, introducing herself and her service and the giving and receiving of information.

MAKING IT INFORMAL

The first antenatal visit and contact leading up to the first antenatal visit was informal. The informality was noted in the tone and content of the answer-phone message, the venue of the first meeting and the way in which the midwife dressed.

Making First Contact

The informality started with the woman contacting the midwife by phone. I listened to all the midwives' recorded messages and found them to have a general informal message for the household. It stated the names of the members of the household and asked the caller to leave a message. After the informal message for the household there followed a specific message on how to contact the midwife. One recorded message was done by a child in the household using the above format. Initially when I listened to the child's message I thought I had got the wrong phone number, put the phone down and redialed. All the other messages were recorded by the midwife. When they received a message midwives phoned the women back and made an appointment for the first antenatal visit.

Informality of Home

Undertaking the first visit in a home environment helped to contribute to this atmosphere of informality. The midwives and the women were seated in a comfortable non-clinical setting. The content of the visit aside, I could easily have been observing friends sitting around chatting and looking at pamphlets.

Midwives discussing the home visit said:

> *I think, yeah, that you have to go to their homes. Whether you have to do all the ante-natals at home, probably not, but I think that initial visit, because that gives you all heaps of information (...) you're on the back foot, like you're in their home you're a guest in their home and they call the tunes* (Midwife Gloria,1:758).

The informality suggested here is that of being a visitor in the woman's home rather than the pregnant woman being a client or even a patient at a clinic. Within this framework of informality the midwives believe that it is easier to obtain a better picture of the woman and her surroundings.

> *I think it's really quite important to do the first visit early on in pregnancy in the home with the woman so you can get that picture of where things are* (Midwife, Rena, 2:97).

One visit was held in the midwife's home and took place in her lounge. The midwife sat on the floor throughout the whole visit with the pregnant woman sitting on a settee. This midwife prefers to undertake the visit in her own home as she has more control over the visit and

there are fewer interruptions. This did not deter from the informal atmosphere that was observed to have been created.

> *I just set up a first appointment and ask whether they want me to see them at their place or my place basically. I prefer personally to do the visits here because I can organise it a bit better* (Midwife Joan, 1:113).

Informally of Dress

Another contributing factor to the informality was that all participants also dressed casually. When asked about dress code one midwife said:

> *Well I always try and not look scruffy actually which is hard sometimes. Depending on what's available in the cupboards at the time. Depending if the ironing woman has been. But I do make an effort not to look scruffy* (Midwife Rena, 2:191).

Another midwife had thought more about her dress and considered how women might feel if she wore certain clothes.

> *I don't over-dress because I am also, like my son often says to me why don't you wear some of these tight fitting things. Well I read somewhere, where you shouldn't emphasise the fact that you are slim, or you are not pregnant, you know, you don't have this big tummy because women are conscious of the fact that, because some men may say oh you are getting fat. I don't want to have an executive look because they want to, need to be comfortable with you and I often dress quite down really* (Midwife Dana, 2:483).

The midwives were making the visit informal through their answer phone messages, home visiting and their dress. From the interviews with the midwives it was apparent that they were aware of this informality. By making the first antenatal visit informal the midwives in this study were able to obtain information from women that they might not have otherwise, deliver a service in a place desirable to women and set the scene for the future that would affect the on-going relationship.

INTRODUCTION OF SELF AND SERVICE

To set the stage for the future the midwives introduced themselves to the women and gave an outline of their past professional experience. Personal information was given by some midwives.

Giving of self

The midwives also gave the women information of both a personal and professional nature. The kind of information that midwives gave women included their past nursing and midwifery experience as well as some personal details about their family situation such as:

> *I did my nursing training in the 1980s and I've worked in the antenatal area and after I had a couple of children I worked in a neonatal unit for a few years then went back to delivery and came over to this province for my husband's work* (Midwife Rena. FAV: 11).

> *I come from a nursing background. I have spent many hours in the real technical areas from theatre, neonatal so I am very comfortable with small babies* (Midwife Joan, FAV: 11).

Later on in the visit Midwife Joan says:

> *I'm a nurse from way back going right through the technical field. I have got three kids of my own so I have experienced a few of the things that you are likely to experience* (Midwife Joan, FAV: 51).

Most midwives gave this kind of information near the beginning of the visit. One midwife having given her professional history, remembered at the end of the visit to give some personal information to the woman.

> *The other thing I usually talk about is that I am married and I have two children. They* (the children) *often page me at 3.00 o'clock if I'm not in* (at home) *today so that's very good. They are 11 and 13 so they are older now* (Midwife Dana, FAV: 652).

The giving of personal details and past experiences adds to the informality of the visit but also gives women information on which to formulate opinions on whether the midwife was experienced in delivering midwifery care. One woman was in impressed with the midwife's theatre experience and in a conversation with me said:

> *She has been through theatre and stuff like that. Pretty weird.*
> *Why?*
> *Because anyone* (going) *from theatre to delivering babies is something else* (Carol,1: 164).

Midwives informing the women of their past professional experience and personal life adds to the informality of the situation and gives credence to the midwife's practice.

Explaining the service

The introduction of self and service included the giving of information on what services the midwife could offer. Time was spent explaining to women what the midwife could do and how the midwifery services were delivered. The midwives made it very clear to women how accessible they were and explained the use of a backup colleague.

> *Basically if you are worried about something you should call me. And I would always rather that you did than that you fretted for a month till the next visit when its something we could have easily sorted out over the phone. Basically don't hesitate to call* (Midwife Bridget, FAV: 806).

> *I am available 24 hours a day seven days a week. If I am not around another midwife carries my locator so you can always get somebody. We try and work office hours. But you know if you need us we are available. OK so if you've got any concerns don't leave it and think oh gosh it is 11.00 p.m. at night, you know, if it's a worry, if it's a biggee* (Midwife Joan, FAV: 294).

> *I'm on call 24 hours a day 7 days a week. If I'm not then somebody else is covering for me and you will probably meet her. It's usually* (name). *I don't know whether you have heard of her* (Midwife Dana, FAV: 48).

> *Yep, so ring my home number first and if I'm not home leave a message if it's not urgent, and for urgent ring my pager number. It is easier to contact us this way* (Midwife Cath, FAV: 287).

Although all the midwives in this study were independent midwives working with their own caseload, there was always some midwifery cover available when the chosen midwife was not available. The midwives introduced this service to the women by giving them a pamphlet on the subject and explaining it to them.

> *So this one here* (pamphlet) *is a light blue bit of paper that you can put in an important place somewhere so you don't lose it. That is the midwifery group that I belong to. I think I said on the phone I'm in a group of four midwives* (Midwife Bridget, FAV: 609).

> *I am very fortunate with my working group. I worked with* (name) *who has her own clients but we work very closely together so that if you have a long birth for instance, you might see us both at the birth* (Midwife Joan, FAV: 43).

Women appreciated the contactability usually from the midwife being on call. One woman said:

> *I mean she was special because* ***she was there*** *and you could contact her any time if you had to, you know* (Dot, 1: 53).

A woman reflecting on her last pregnancy highlighted the importance of midwifery care especially in the post natal period:

> *I think, I think the biggest thing for me was that, is that if I'd had a doctor, I think if I'd gone with the GP then I wouldn't have had anyone to help me with all the breast feeding problems he wouldn't have been there and to me that just sums it up. Because that was*

> *such a big part, umm it was all consuming for that period of time. It really was and* ***Gloria was there*** (Karen, 460:1).

Midwives recognise that they are working within the boundaries of normal pregnancy and childbirth and informed women of that.

> *The midwives only work with normal so if there is anything that happens outside of normal we would refer you very early to a specialist* (Midwife Joan, FAV: 28).

> *I am a specialist in anything to do with normal pregnancy, normal labour and birth and normal post natal time. So anything to do with the pregnancy or anything that might be to do with the pregnancy you should see me about these* (Midwife Bridget, FAV: 693).

When interviewed after this first antenatal visit, Midwife Bridget (1: 179) called herself "a very realistic natural birther".

The normalising of birth by the midwives entailed viewing birth as a normal physiological process. This may involve changing the view of childbirth from a pathological condition to a physiological process (Cardale, 1994). Midwives claim their area of expertise to be natural childbearing, respecting pregnancy and birth as a state of health (Kaufman, 1993). Silverton (, 1993, p.108) states that:

> it could be argued that since the midwife is the practitioner of the normal, there is no role for the GP in the antenatal care of normal women, and should complications arise, these should be referred by the midwife directly to the obstetrician.

Donley (1986, p.15) calls the midwife "the guardian of normal birth", while Bergstron (1997, p.420) believes that normal is not an appropriate

word to "use in relation to many things that midwives are concerned with" as the word normal comes from measurement and statistical probability. Bergstron puts forward the words "natural" and "healthy" as interchangeable and alternatives to the word normal.

The introduction of the self and the midwifery service on offer to women helped to set the scene for future care. Flint's (1993, p.70-71) description of the access that women have to their midwife is similar to that found in this study and she goes on to offers midwives advice:

> When a woman has a midwife who is 'her lead professional' or in other words, "her midwife" she has access to that midwife 24 hours a day, and can bleep her to discuss different aspects of the pregnancy whenever she needs to (...) it is a good idea to get women trained so that they not only leave their telephone number, but a comprehensive message when they bleep the midwife.

With the midwives introducing themselves, their service, and the concept of normality, women had a good insight into the service that they were likely receive now and in the future. With these building blocks in place the stage was being set and the most time consuming part of the first antenatal visit, the giving and obtaining of information, could begin.

GIVING AND OBTAINING INFORMATION

By far the major part of the first antenatal visit composed of the giving and obtaining of information.

It is a full-on visit you know and it's like, is it too much, you know? (Midwife Bridget, 1:452).

... it is very hard to find that balance because there is a lot. And I was saying that to her. There is a lot to do today. There is the information gathering, there is the information inputting and there is an antenatal visit (Midwife Bridget, 1:340).

The information gathering involves the information needed for the antenatal notes. The information inputting relates to the giving of information to the pregnant woman and the antenatal visit involves all the rest of the first antenatal visit including making it informal.

Providing Standardised Care

Similar forms and resources were used by the midwife irrespective of the woman's needs. Therefore in many cases the care was "standardised". There was some individualisation of caring as outlined but it was observed that standardised care was being given.

Giving Information

The process of informing women was led by the midwife and followed the same format.

For me well, I think it's an information sharing and gathering on my part (Midwife Dana, 1:134).

Some midwives used a checklist as well as an information pack to make sure all the information that was considered necessary was given to the woman.

> *With each person I have that checklist that I pretty much follow with people. There are some things that are pretty* ***standard*** *right so I would give everybody the RHA information and the complaints procedure information, bounty book* (information booklet) *and the pregnancy book and I will give most people, I will offer most people the sort of things that are on the list* (Midwife Cath, 1: 208).

One midwife also considered that the information could be useful for others as well.

> *But I make them all up the same, umm, because maybe the information gets passed onto their friends or a friend's around and they pick the book up and have a look at it and maybe they'll learn something* (Midwife Gloria, 1:967).

The type of information that was given out is listed in appendix G. The order in which the information was given out was directed by the pamphlets that the midwife had put together in a pack covering a variety of topics.

> *I've got a full range of 12 or 15* (pamphlets). *Throughout the pregnancy I like to give a range of information but I know that I am a bit brain dead so I give all the pamphlets out at the beginning and then add to them if there is anything extra and they range through from resolutions committee, I tell them about advocacy, how to access some of your dietary things, I've got two pamphlets on that,* (I tell them about) *listeria, cot death; you know all those general*

information type things. Things ranging right through to immunisation (Midwife Joan, 1: 150).

Oh that pamphlet. It's about the classes after the birth. The post natal classes for Parent Centre (Midwife Bridget, FAV: 534).

If the pamphlet was not available then the topic tended not to be discussed.

I used to give them out one on thrush and there's no more of those being made so I forget to talk about it now you see (Midwife Dana, 2: 305).

The topic of alcohol and smoking in pregnancy were covered extensively. This information was even given to women who did not need it as can be seen during the conversation between Midwife Dana and Jana.

You're not a drinker. OK so you don't drink at all really (Midwife Dana)
No (Jana)
It's just to say really (giving a pamphlet on alcohol in pregnancy) *that they don't know how much drink is safe or what is a safe level of alcohol, although some things came out a while ago to say that you could have certain amounts of alcohol but I wouldn't advise you to go drinking as much as they said that you could take! But I think the safest thing is not to drink at all really. If you do have a drink don't do it on an empty stomach, have it with a meal or have a drink of milk or have a cheese and something, you know that if you drink on an empty stomach it goes straight into your blood stream. Basically if you get a lot into your blood stream then the baby really gets a good hit as well. It's called* (fetal) *alcohol syndrome which*

> *really the baby is affected by it. They have certain characteristics on their face and things. It's sort of slow development I suppose from the alcohol so it's probably safest not to drink* (Midwife Dana and Jana, FAV: 509).

Three issues arose from this conversation: firstly as the woman stated that she did not drink alcohol giving her the information would not be a priority, second not all the information given was accurate and third the amount of information given with little time for the woman to respond. There is adequate literature addressing the issue of alcohol and pregnancy. The Alcohol Liquor Advisory Council (ALAC) provides current research on alcohol. It is not clear exactly how much alcohol puts a baby at risk (Gardner, 1997; Kalderimis, 1998). The message that should be given out to all pregnant women is that no alcohol should be drunk during pregnancy (Kalderimis, 1998). Leversha and Marks (1995, p.430) believe the prevalence of fetal alcohol syndrome and FAE (Fetal Alcohol Effects) in New Zealand are underestimated and go on to state:

> Awareness of the risks of alcohol in pregnancy needs to improve (...) Clear guidelines on alcohol consumption in pregnancy needs to be developed and a consistent message delivered nationally across all groups of health professionals.

Without any input from the woman about the information given, the midwife went straight onto the next topic for discussion.

Alcohol use and other topics to be covered at the first antenatal visit are listed in the Midwives' Handbook for Practice (NZCOM, 1993) and it is recommended that they be discussed by the time the woman is sixteen weeks pregnant. In this study the midwives tried to impart all that information at the first visit even when the women were only ten weeks

pregnant or less. The information that women wanted at this visit will be discussed in the following chapter.

It would seem that the organisation of the pamphlets in the information pack directed what information was given out even if that information was not required. Relevant information is important at every stage of the pregnancy including before, during and after labour (Green, Coupland, & Kitzinger, 1990) and the first antenatal visit is only the beginning of the process of informing women. Informing comprises two aspects: one aspect is to inform women what is going on in their own bodies at the relevant time in the pregnancy and the other is to inform women at the relevant time so that they can make decisions that need to be made throughout pregnancy, birth and the post natal period.

According to the report of the Expert Maternity Group (1993) communication between the pregnant woman and her health professional is recognised as particularly important and the difficulty of presenting unbiased information about maternity care is not easy. The report does recommend that midwives improve their communication skills as part of their on-going education.

> It is the responsibility of health-care professionals to impart information to women and their partners that is accurate and offered at a level accessible to the individual concerned (Churchill, 1995, p. 32).

Information was accessible, through the use of pamphlets, to the women in this study.

Having observed and listened at the antenatal visit I had the impression that too much information was being given out. Over forty years ago

George Miller (1994) proposed that there was a limitation on the ability of individuals to process information. He set that limitation to the magical number of seven, the seven being a measurable "bit" in information theory. Baddeley (1994) recently stated that the number of categories that a person can simultaneously handle averages about 6.5. As Shiffrin and Nosofsky (1994) point out the numbers mentioned in Miller's article are the least significant part of his message. What is significant is that "the span of immediate memory imposes severe limitations on the amount of information that we are able to receive, process and remember" (Miller, 1994, p. 251). There are limitations on the amount of information that can be retained at any one time. The giving of over thirty six different types of information, as found in this study, may be deemed excessive and it is important to be able to identify exactly what information needs to be given out at the time of the first antenatal visit.

Obtaining Information

Alongside information giving was the task of obtaining information, which involved the completion of the standard antenatal notes used by midwives (Appendix H) and the collection of baseline data as described at the beginning of this chapter. The antenatal notes consisted of the birth booking form, pre-natal notes (antenatal notes) and certain parts of the consent form.

One reason given for filling out these notes was that the midwife would leave the completed notes in the hospital and they would be available when the woman went into labour. Five of the women had decided to have a planned hospital birth and only one woman was considering a home birth but had not yet decided.

> *We'll make a set of notes for you to take up to the labour ward which waits until you go into labour* (Midwife Dana, FAV, 136)

It is a long time before a woman who is ten weeks pregnant is likely to go into labour. There is no obvious reason why these notes need to be filled out at this visit. One reason given for obtaining the information for the antenatal notes at the first visit is that it is more convenient for the midwife to complete the task at this time.

> *I suppose you could leave out the history and just meet the woman but at the end of the day that means another visit to do that so in a way it's better just to get it all done. Because I'm thinking about that complaints thing whether it should go together at the first visit or whether it's good to go over it at the next visit. I decided and was thinking about it and thought, I think it's just something else to remember to bring to the woman. It is an added thing for me. Whereas in a way if you get on with it all in the one visit and checking it off, especially taking your time with the history* (Midwife Rena, 2: 79).

It may be more convenient for the midwife to fill out all the forms but it may not be the best time for the woman. A large amount of information was given to women using the pack of pamphlets. Time was also spent filling out the antenatal forms. Given that a first antenatal visit could last up to two hours the practice of giving and receiving information needs to be reconsidered. If, as is suggested by Miller (1994), there is a limit to the amount of information that can be absorbed at any one time, then it is crucial that only the most relevant information be given at the first antenatal visit. When asked what information could be left out one midwife said:

Probably family history and medical history to a certain extent could be. I tend to do it all at once. It could be left out because it is quite a mammoth effort that first visit (Midwife Donna, 1: 288).

Galloway (1994) believes that an important part of the first antenatal visit in hospital is the completion of the antenatal records by the midwife. It may not be such an important part of the first antenatal visit done by an independent midwife. Information can be gathered by the independent midwife over time as she will be the only midwife providing care. By not filling out the antenatal notes at the first visit, the visit could be considerably shortened. Information that needed to be addressed included information identified as important by the woman and specific details on how to contact the midwife. The midwives could then assess the most appropriate time to complete the other tasks.

Giving Choices

Midwives regard the information that was given out to women at this visit was necessary to assist women to make informed decisions in the future.

We are helping you in giving you lots of choices so you can make up your mind about what you would do with (labour) *pain or whatever so that you would instruct me basically* (Midwife Joan, FAV: 24)

(I am) *making it really clear that this is their pregnancy and their baby and their body and that they get to make the choices, you know about what sort of care they are wanting and that there are choices in care and that my role is really to give them as much information as they need. I usually spell that out in the first visit,*

what my role is, and to give them as much information as they need to help support them in their own pregnancy (Midwife Cath, 1: 38).

Brown and Lumley (1994) found in a quantitative study that not having an active say in decision making was associated with a sixfold increase in dissatisfaction among women in their first pregnancy and a fifteenfold increase in dissatisfaction among women having their second or subsequent pregnancy. The findings in Kenny, King, Cameron and Sheill's (1993) quantitative study reinforced the importance of providing women with information in order to make choices for the maternity care which best suits their needs. They did not address the issue of women being overwhelmed by the visit and their ability to focus on all the information that was given.

Providing Individualised Care

In this present study individualised care being offered to pregnant women at the first antenatal visit mainly involved remedies for morning sickness. The knowledge base of the midwives on the subject of complementary therapies varied from some having a very limited knowledge to some having studied complementary therapies in depth.

Complementary therapies

One midwife informed the pregnant woman that she consulted with another midwife who had good knowledge on various complementary therapies.

I worked with (name) *who has her own clients but we work very closely together (...) She brings the added advantage that she has*

> *homeopathy, naturopathy, acupuncture all sorts of added things which I learn from her* (Midwife Joan, FAV: 44).

Three of the midwives in the study used complementary therapies in a limited way or as a sideline to the standard care provided.

> *I know a little bit about it. I don't know a lot and it is something, homeopathy in particular, that I wanted to follow up on. It is a sideline and someone said at a review, it was the College of Midwifery, these things could be charged out as separate things because midwifery actually, there's so many little things that you can draw in from midwifery that you know, homeopathy, acupuncture, acupressure, massage, all those things which are all helpful in your practice, but they are sidelines* (Midwife Dana, 2: 466).

Another midwife discussed a woman's sensitivity to candida albicans (thrush) and her fear of developing it in this pregnancy. The midwife gave her a little information on the subject but knowing her limitations she recommended the woman needed "a good homeopath" (Midwife Gloria, FAV: 862).

> *You can take either yoghurt or tablets or whatever, just to keep the gut ticking along so you don't get thrush* (Midwife Gloria, 1: 913).

Another midwife tells women that she is not qualified in any complementary therapies.

> *I'm not overt about it* (complementary therapies). *A little bit about homeopathy, a little bit about massage but I am not qualified in anything and I always tell the women that* (Midwife Rena, 2: 155).

One midwife was qualified in complementary therapies but she waited for direction from women as to their use. This midwife preferred to be led by the woman and felt the responsibility for the use of complementary therapies lay with the woman. If anything should go wrong the midwife did not believe she should be held accountable.

> *If they use them then that's fine and I am quite comfortable with that, but be really clear that they are taking that responsibility themselves and that even though sometimes they might be safer than having medical treatment but there still has to be a few more questions around them. There is usually a bit more discussions around that. Finding out where they are with them. Quite often I will say to people if they don't use those normally then possibly it might be a good idea not to use any, be safe not to use any. I could try to say to provide that there is an option but not to sort of push them one way or another but to find out where they are with it* (Midwife Cath, 1: 295).

The term 'complementary therapy' is used when treatments work alongside conventional medicine (Hotchin, 1996). In the case of midwifery some treatments being used by women are used alongside the standard care being offered by midwives. While midwives are showing interest in the use of complementary therapies and there are plenty of articles on the subject related to midwifery there is very little published research (Hotchin).

Some midwives have developed knowledge in the area of complementary therapy because of pregnant women's interest. Other midwives have a particular interest in complementary therapy themselves.

Getting to Know Each Other

A relationship was beginning to develop between the midwife and the pregnant woman. This was developed within an atmosphere of informality, through the introduction of the midwife and her services and the exchange of information. One midwife described the development of the relationship by saying:

> *An antenatal visit is the start of the relationship. The sort of not quite chit chat but, you know what I mean, the sort of getting to know each other* (Midwife Bridget, 1: 344).

One midwife was aware of taking on the responsibility of care over a period of time.

> *You establish some of the relationship and it's sort of, it's sort of like, making that commitment to be involved in that pregnancy with her. It's providing the opportunity for what needs to come up with her whatever that is* (Midwife Cath, 1:193).

Some midwives identified working within a relationship that they defined as a partnership.

> *I guess the whole philosophy of working in partnership with women is how I want to work anyway. Like I always wanted to work like that before I became a midwife so that's the thing that is really important to me* (Midwife Cath, 1:9).

> *I think probably the title* (partnership) *that I work under says it all for me - partnership, pregnancy care and for me it's trying to*

> *develop a liaison with a woman and the family so that the woman is the stronger power of our partnership* (Midwife Joan, 1:7).

Other midwives did not identify the relationship as a partnership but preferred to look at it as mutual respect or some form of friendship.

> *It's just that you want to be friends. Well it's a professional friendship and in some people you are actually more like a friend than other people* (Midwife Rena, 2: 160).

> *I don't think it is a partnership. They* (midwifery authors) *talk about us (...), about respecting each other's values I think isn't it. It's about her, the woman respecting me professionally, expertise or opinion or whatever you want to call it and it's about me respecting her values and her beliefs and taking on board what she needs (...) Well it's not a real friendship because you don't see them again* (after the post natal period) *do you? You know unless they get pregnant again and it's lovely to go back and see them all again but it's not a real friendship* (Midwife Dana, 1:152).

Tinkler (1998, p.34) believes an established relationship between women and midwives enable women to feel:

> more at ease generally, to feel that choices and decisions were informed and made in partnership with midwives; to access information; and to feel confident about the pregnancy, labour and delivery.

Guilliland and Pairman (1995) defined the midwifery relationship as a partnership. The Midwifery Handbook for Practice also maintains that "midwifery care takes place in partnership" (NZCOM, 1993, p. 7). According to Gooch (1989. P.45) it is in partnership that a midwife's

status would become that of a "true practitioner, recognised by both clients and doctors". Bayntun-Lees (1992) believes partnership means establishing a close relationship based on equality and mutual commitment, emphasising teaching to enable individuals to make informed choices and to participate actively in their care.

Friendship was another term used by midwives in this study to describe their relationship with women. Friendship is voluntary and friends choose the extent to which they will accommodate each other, there is an exchange between friends that includes intimacy and love often with a sense of history (Caroline, 1993). Caroline, in her concept analysis of a close friendship, goes on to describe the consequences of friendship which include the feeling of being loved, connected, enhanced self esteem and empowerment, providing companionship and social support. In an analysis of the relationship observed, the woman and the midwife at the first antenatal visit would not meet the requirements of friendship and so the midwife/woman relationship is not a true friendship. Once the need for the midwifery relationship is over the individuals do not have the bond of affection or commitment to each other necessary for the relationship to continue (Pairman, 1996).

Midwives seem to have different views when trying to describe what their relationship is with women. Is it a friendship or is it a partnership? On observation it would seem that the relationship had elements of a developing friendship. It was observed that there was a considerable amount of laughter between the midwife and the woman, they were seated in a relaxed fashion and showed signs that the midwives were attempting to empower women by giving them information needed to make their own decisions, and social support was being offered. The fact that the relationship is not totally voluntary, having been entered

into because of the woman's need for the midwife's professional care and support, the word friendship may be an inappropriate description of the relationship (Bignold, Cribb, & Ball, 1995). Befriending may be a more appropriate word to use as it involves "emotional labour which is defined as listening, being there, talking and waiting mixed with giving direction, advice or actively making plans" (Bignold, Cribb & Ball, 1995, p.178). Pairman, discussing her research at the NZCOM Conference in 1998, brought together the concepts of partnership and friendship. "Midwifery partnership means professional friendship. A term which advances our understanding of the relationship midwives and women have together, including its significance at a personal, professional and political level" (Pairman, 1998, p.3). Pairman's findings are congruent with the findings of the present study.

The relationship as a partnership was difficult for some midwives to accept. Sylvester and McTavish (1998, p.73-74) defined partnership as "an interpersonal relationship between two or more people where goals are set using a collaborative process, to the benefit of each partner". At no time during the first antenatal visit did the midwife try to find out what kind of relationship the woman wanted nor were there any signs of goal setting. Without this kind of collaboration there is a possibility that the relationship being offered by the midwife may not be the kind required or desired. This was identified by one midwife.

> *Sometimes you get it wrong. You get people who are not wanting to get all that* (information) *from you. A couple of people gave me flack and I think it was because I gave them too much* (information). *It's not what they were wanting. They wanted to keep it very, almost doctor like. Come in and do my blood pressure and check*

my wee and they didn't want all that other stuff. So you get it wrong (Midwife Donna, 2: 510).

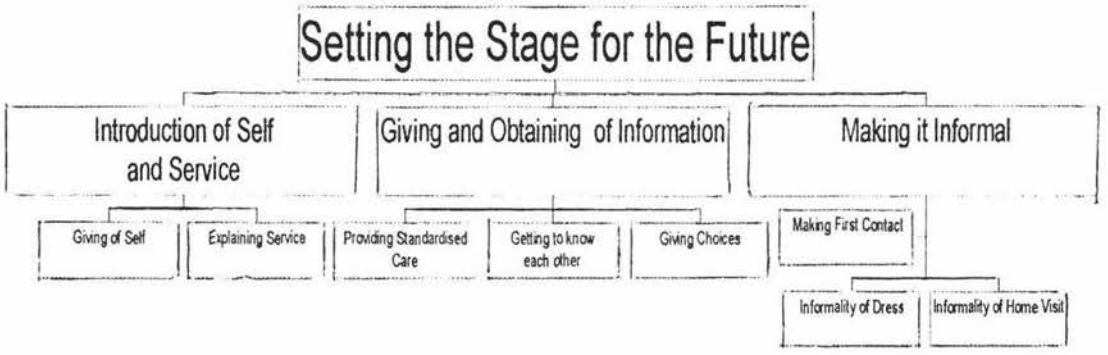
Relationships with midwives who had attended the women in the past were observed to be different from women who were pregnant for the first time. There was more reflection on past shared experiences and women were visibly more relaxed.

I guess the main thing for me was just that it was really nice that it was very connecting with me and very connecting with her and finding out where she is and sort of just setting the stage for setting things up for her antenatal care (Midwife Cath, 1: 03).

There was not enough data to be able to draw any conclusions about the differences observed between the three women who were pregnant for the first time and other pregnant women. The present research can only highlight that differences were noted.

The part of the model presented in this chapter is presented overleaf in diagrammatic form. The midwives are setting the stage for the future, with the introductions, the information exchange and their attempts to keep the visit informal.

Setting The Stage
Figure 1



SUMMARY

The first antenatal visit is a full visit and can last up to two hours for a payment to the midwife of only $25. I have questioned the amount of information that was given out and the necessity of filling out the antenatal records. The relationship as a partnership has been disputed by the midwives and defining it as friendship has not been accepted. A professional friendship seems to fit more comfortably with the observations that took place. With the stage being set by the midwife, a woman could expect that future visits made by the midwife would be informative and that she would have the opportunity to make decisions concerning her care in an atmosphere of informality. In Chapter four the paradoxes that exist when independent midwives try and deliver maternity services to women are examined.

CHAPTER 4

THE PARADOXES

INTRODUCTION

The previous chapter examined the involvement of the midwife in the context of the first antenatal visit. This chapter takes a deeper look at the midwives' encounters and unearths several paradoxes that exist. These paradoxes involve the delivering of midwifery care which midwives are contracted to provide, against trying to provide woman-centred care, trying to run a successful business and maintain a good relationships with the women's GPs. The synonyms given for paradox are contradiction, inconsistency and incongruity (Microsoft, 1995). Incongruencies, inconsistencies and contradictions will be identified within the paradoxes.

THE PARADOXES

The paradoxes identified pull midwives in different directions and may impact on the delivery of excellent midwifery. Midwives identified the difficulties they experienced in trying to meet the needs of women. The midwives did not use the words "woman-centred care" but it became obvious from the analysis of the data that midwives were trying to provide woman-centred care.

Midwives identified the difficulties that they encountered in delivering maternity services in a business environment. The midwives' philosophical beliefs were not consistent with the financial rewards

available. Midwives are trying to provide a service based on their philosophical beliefs which are not reflected in the contract that they are required to work with. One of the financial frustrations, involved GPs having access to the midwives' budget. This means that if a GP sees a pregnant woman for a pregnancy related condition and the doctor is not the LMC then the doctor can claim a fee from the Health Funding Authority (HFA) that will be paid to the GP out of the LMC's budget. The LMC has no control over this system. Midwives were very frustrated that a GP was able to claim from the midwives' budget, without the midwife having any control.

Independent Midwifery Care and Woman-centred Care

The first paradox identified was that of trying to provide an independent midwifery service while also trying to deliver woman-centred care. Woman-centred care is defined as the woman being "the focus of midwifery care, and it is she, in partnership with the midwife, who identifies her priorities for care" (NZCOM, 1993, p.48). Woman-centred care is seen as good maternity care (Expert Maternity Group, 1993; Taylor, 1994; Williamson & Thomson, 1996). It is a philosophy of practice as much as a way of practicing. The need to provide woman-centred maternity services, taking account of women's views and specifically addressing their need for choice, control and continuity of care, has been advocated (Laslett, Brown, & Lumley, 1997; Taylor, 1994; Williams, 1994; Williamson & Thomson, 1996). Woman-centred care has been well defined in the Changing Childbirth Report (Expert Maternity Group, 1993) and upheld by the NZCOM. The important principles promoted in this report include:

- Every woman is unique and services should recognise the special characteristics of the population they are designed to serve.

- The woman and, if she wishes, her partner, should be encouraged to be closely involved in the planning of her care.
- Every woman should be given the name of an individual midwife who works locally, to whom she can go for advice and help throughout her pregnancy.
- Antenatal care should take part as far as is practicable in the local community with ready access to specialist advice should it be necessary.
- The woman should feel secure in the knowledge that she can make her choices after full discussion of all the issues with the professionals involved in her care.

In this present study, Dana partly expressed woman-centred care as "vibes" that women were giving in the early stages of the midwife-women relationship she stated:

> (it was like) *trying to get the feeling for this* (what women want) *without knowing somebody particularly well and you rely a lot on not so much on what is being said as what vibes you're feeling* (Midwife Dana, 2:524).

Woman-centred care was defined by one midwife as individualised care.

> *That's the thing I really like about being independent is that I like not having a routine with every person because every person's different and so I like actually being able to give care to them as an individual* (Midwife Cath, 1: 220).

For Bridget woman-centred care meant that the person she had the most important relationship with would be the woman. If the woman decided not to involve other members of her family in this pregnancy

that was her choice. The woman, not the family and not the father, was the centre of care.

> *Because I feel my main relationship is with her. And it is with him and with her mother secondarily I suppose* (Midwife Bridget, 1:380).

With the main relationship being with women it was to women that the information was directed. Women were given a lot of information at the first antenatal visit and were encouraged to be part of the decision making process.

> *This is your pregnancy and your birth. It is your decisions that you are making and I am here to help you in these decisions. I am not to tell you what it is. Because there is not just one way of doing things* (Midwife Bridget, FAV:1202).

The midwives in this study were able to verbalise in their own way their belief in Woman-centred care but in practice there were some inconsistencies. Standardised care, as reflected in the use of the antenatal notes and the information pack, was being delivered to women regardless of whether the woman needed it or not. There seemed to be little understanding about what women needed and wanted at the first antenatal visit. This may partly be due to the lack of research into this area.

Research into woman-centred care may assist midwives in addressing the difficulties that can arise for the provider. Gloria felt there was too much emphasis on centering care and meeting the needs of women and not enough discussion about keeping midwives safe from overwork and stress.

> *That it's all women's rights. And I just sit back and take a big breath and say yeah yeah that's fine but what happens, who looks after the midwives and what about our* rights. *Our job's on the line* (Midwife Gloria, 1: 259).

The example she gave was of a woman wanting a home birth after experiencing difficulty with her last home birth. Gloria refused to attend the home birth but feels that she may be criticised for her decision.

> *I've got one coming up at the moment which I think is going to be a problem and she's a girl who I had a home birth on last time but we had difficulty with the shoulders. And I had said to her at the time, you have another birth, I said I will not do it at home. You will have to be in hospital. So she got pregnant again and rung me up and we went through it again and I said I will not do this at home, it has to be done in the hospital. And so she's rung around all the other midwives to find out, to find somebody to do it and they've fortunately for me, they've all said no* (Midwife Gloria, 1: 223).

Declining to meet a client's wishes may mean that the midwife runs the risk of losing the woman as a client and so losing the financial rewards associated with providing care for that client. The midwife has to weigh up the need for business with the need to keep herself and her client safe.

The partnership should be able to accommodate the needs of both the midwife and the women. Only the midwife's responsibility to the client, to the wider community and to colleagues and the profession are identified in the midwives' Code of Ethics (NZCOM, 1993), and the gap is also present in the literature. What is stated in the Code of Ethics is

that midwives are expected to "support and sustain each other in their professional roles and actively nurture their own and others; sense of self worth" (p. 12). The midwife has a responsibility to ensure that she has a balanced life and workload.

Being on call twenty-four hours a day seven days a week is a big commitment for midwives. It would seem that the demands of women are very high as are the midwives desires to offer women a quality service. At the moment woman-centred care gives women unlimited access to a midwife (Flint, 1993). Midwives are keen to deliver a high quality service but the needs and the demands of women can be too great.

> *They are quite demanding of you. They are quite demanding of you and they will ring you up at ridiculous times 7 p.m. on a Friday night and say "oh I have had this pain all week", you know and you think oh* (Midwife Dana, 2:449).

Rena, as a relatively new independent midwife, said:

> *When you first start out you really try to accommodate women and you then end up going over the score a wee bit* (Midwife Rena, 2:115).

It would seem from the literature that some midwives want women to be honest, to have knowledge and respect of the legal status of midwives and to agree to abide by the midwives' protocols. Midwives want women to be on time for appointments, to understand and meet their obligations to their midwife and to trust in birth and in their midwife. (What midwives want from their clients, 1995). If midwives know what they want from women then there needs to be some process for

communicating this to women. This type of communication between the midwives and the women did not take place at the first antenatal visit.

When discussing the business side of midwifery, Rena identified the need for guidelines.

> *I think mainly trying to keep it like a business as far as visits and time wise are concerned. I think that's important because when you first start out you really try to accommodate women and you then end up really going over the score a wee bit. Maybe if that was made clear from the start in some way some how then it might be advantageous not to go over the score because you will end up burning yourself out completely and it is not worth it* (Midwife Rena, 2: 137).

"Burning yourself out" is the main problem facing midwives in this study as they try and deliver a woman-centred service. At the first antenatal visit the midwives are showing signs of trying to adopt some of the important aspects of woman-centred care. All the women had a named midwife who was on call and accessible twenty-four hours a day. The antenatal visit took place in the community, and women were informed that they would be encouraged to take part in decision making in the future, thus the foundations for the development of woman-centred care for now and in the future were laid. The question now needing to be addressed is: how can midwives and women work together to develop a service that is fair to women and midwives?

The paradox is that if midwives continue to meet the needs of women as discussed in this study, then the self employed independent midwife may not survive. There needs to be a balance and it would seem that this balance, for the midwives in this study, has not been reached.

Independent Maternity Care versus Running a Business

The attempts to deliver woman-centred care take place alongside the midwife running her own business with both financial and legal responsibilities. Woman-centred care takes time. Time is needed to develop the relationship, to provide education to allow women to make informed decisions and to deliver the care in the community. The paradox is that the midwife is being paid $25 for the first antenatal visit which is not commensurate with the demands of woman-centred care.

For a business to be successful there is a need to gain and maintain a solid client base. This is described by Gloria:

> *But that initial visit is actually quite important because we're a business and if they don't like you then they say "n,o I don't want you". Not that I've had anybody do that but you know, they're entitled to do that and umm, and maybe they don't recommend you to anyone else. And so you really do put on a bit of a show* (Midwife Gloria, 1:1317).

Under the old system, where midwives were employed by a hospital, they did not need to gain or maintain a client base.

Running a business also involves managing contracts, legal requirements and finances. Dana leaves some of the paper work to her husband as her knowledge about tax and GST (Government Service Tax) is limited.

> *I fill out the paper and do the claiming, he* (husband) *does the GST and the tax and stuff like that, so I don't do that. I have to say I am*

very naive about it, I wouldn't know where to begin (Midwife Dana, 1: 379).

The business side of midwifery is new and the independent midwives do not seem confident in it. On asking a midwife if she was prepared for the business side of practice she replied:

Not at all, absolutely not at all. No. I just watched other people and kept my ears open and picked lots of little bits up and things like that (Midwife Rena,1:125).

One midwife was very unhappy with the payment system. A lot of time was taken up with completing forms and a lot of frustrations were experienced over claiming payment. Midwife Cath expressed her feelings about the whole payment system by saying:

The system we are being paid by absolutely stinks (...) it just makes no sense at all. It's completely frustrating, it's really unjust and it doesn't seem to matter how much noise we make about it, it doesn't change. It's changed a tiny little bit (Midwife Cath, 1:328).

From observing the first antenatal visit the part of providing a service that is related to running a midwifery business is not well handled. The foundations being laid at this visit for the future are not conducive to a well-run business.

With midwives being on call 24 hours a day seven days a week, it was surprising that none of the midwives in this study employed an assistant to undertake their paperwork. Caroline Flint, a well-known English midwife, found an assistant to be invaluable in her practice (Flint, 1993). This assistant answers the phone, makes appointments, relays messages and runs an invoicing system producing all the letters

necessary. This leaves more free time for the midwife either to practice midwifery or to have time to herself. A good assistant would make up for the midwife's lack of business knowledge thus removing a considerable amount of stress.

The payment received for being the LMC is to cover the cost of delivering appropriate maternity care. There is nothing to say that the midwife has to do everything herself. A full time assistant could be employed to serve a number of midwives thus sharing the costs.

With the present payment system it would be quicker and more profitable if the first visit was a shorter visit. This would involve informing women of the service and providing only the amount of information required by the individual women at their particular stage of pregnancy. The process of form filling could easily wait until women are around sixteen weeks pregnant when they signed up with their midwife who then officially becomes the LMC. Many women may even be able to fill out most of the forms themselves.

Visiting the woman's home during the antenatal period may not be cost effective for the midwife. This places midwives in a dilemma as home visiting is more congruent with woman-centred care. The midwife in this study who held the first antenatal visit in her own home had more control over her time. She did not have to deal with unplanned interruptions in the woman's home and therefore the visit was of shorter duration. A cost-benefit analysis would be able to weigh up the monetary benefits against the disadvantages and help in deciding whether home visiting should continue. More business planning needs to take place so as to deliver a good business plan for future midwifery practice.

Independent Midwifery Care versus Competition

Running an independent midwifery business can bring midwives into direct competition with the medical profession as GPs and midwives are competing for the same clients but offering a different service. GPs and midwives should be collaborating with each other in order that the woman receives the best possible care during her pregnancy, rather than competing against each other.

Women may need to access medical care from a GP during their pregnancy for non-pregnancy related issues. All women in this study were instructed by the midwife to consult with them first before going to see a GP to prevent GPs from claiming a portion of the midwife's budget.

> *This is probably an appropriate time to just say to you that we are professionals in our own right so we can prescribe anything to do with pregnancy. OK. So if you have, for instance, a urinary infection or vaginal infection we can write* (a prescription) *for that. We can help you out with that. If we think it's medical, for instance if you had an asthma attack, we would need to send you to your GP. But we do suggest that you ring us first and check out what it might be* (Midwife Jean, FAV:353).

Informing women of what a midwife can do is, in a way, clarifying what service they do or do not offer. Instructing women to contact the midwife for a non midwifery event is not a satisfactory situation in which to place women. Midwives need to work towards changing GP's access to their budget and refrain from controlling women's rights to contact their GP when they wish. Another midwife went on to explain the situation to one woman by saying:

Sometimes it's really clear that it's a pregnancy-related thing but sometimes it's hard to tell, like infections being treated as part of pregnancy, so if you are not sure just phone me and have a chat (Midwife Cath, FAV: 247).

They (GPs) *basically have access to our budget as much as they want and what's more is when they do it during the weekend or out of hours, there is no extra payment for us when we do that sort of work* (visit the women out of normal working hours). *When they see our woman outside working hours the payment to them is $45 so they take* (the payment received by the midwife for) *half the trimester visit in one ten minute weekend visit to their surgery* (Midwife Cath, 1:352).

Under the present arrangements if a woman sees a GP for a pregnancy-related condition the GP can claim on the midwife's budget. On discussing this with the HFA advisor in Hamilton (Personal Communication HFA Advisor, 1998) she informed me that the GP should only be charging for the visit if the GP has made every effort to contact the midwife to no avail or that the midwife had agreed to the payment. The midwife may not agree and arrange to see the woman herself. This did not seem to be happening. All the midwives in this study carried a pager and had answer-phones and could easily be contacted. One midwife gave an example:

She (the pregnant woman) *had gone to the doctor with a sore throat and they looked down her throat and said it's red you must have heart burn and so therefore it's pregnancy-related and charged me $45! So I wrote a letter to the doctor and said I didn't really feel that was warranted and could I have my $45 back and then they had a meeting and said no they thought it was pregnancy-related to them.*

> *I have to say she went back to her own GP a few days later and got some antibiotics for a sore throat* (Midwife Dana, 1:390).

When the woman was prescribed antibiotics she would have paid for that consultation, and the GP would not have claimed a fee off the midwife's budget. This incident was nearly a year ago and this midwife had still not received a reimbursement of the $45. Gloria questions this practice by saying:

> *And it gets whacked off me (laugh). No other profession has money docked from their module* (bulk funding) *without any consultation. I mean like who would put up with it?* (Midwife Gloria, 1:870)

Midwives feel they have to prepare women now for the future use of the GP services if they are to be the LMC thus preventing unnecessary money being taken off their budget. This payment scheme is not conducive to good collaboration between GPs and midwives.

The media have been involved in fueling this discomfort. Masters (1998, p.A13), writing in the New Zealand Herald, describes the maternity scheme as "a scheme that has pitted midwife against GP and vice-versa in the name of putting the lid on rising costs". She goes on to describe the history behind the rivalry by stating that:

> The trouble started in 1990 with a change to the Nurses Act that meant that midwives were able to claim the same fee and rates as GPs. Often they collected more because they spent more hours with women. Some doctors resented this (p.A13).

The arguments put forward by the media against midwives were that midwives were not safe to practice. In the early 1990s television programmes (Television New Zealand, 1992a; Television New Zealand,

1992b) and a leading newspaper article (My life is ruined, 1992) singled out midwives for criticism even though the incidents highlighted took place before the change to the Nurses Act in 1990 which allowed midwives to take full responsibility for normal pregnancy care. Members of the medical profession were in charge of the cases in question. In the past midwives had no statistics regarding their practice to use to defend themselves against this type of publicity.

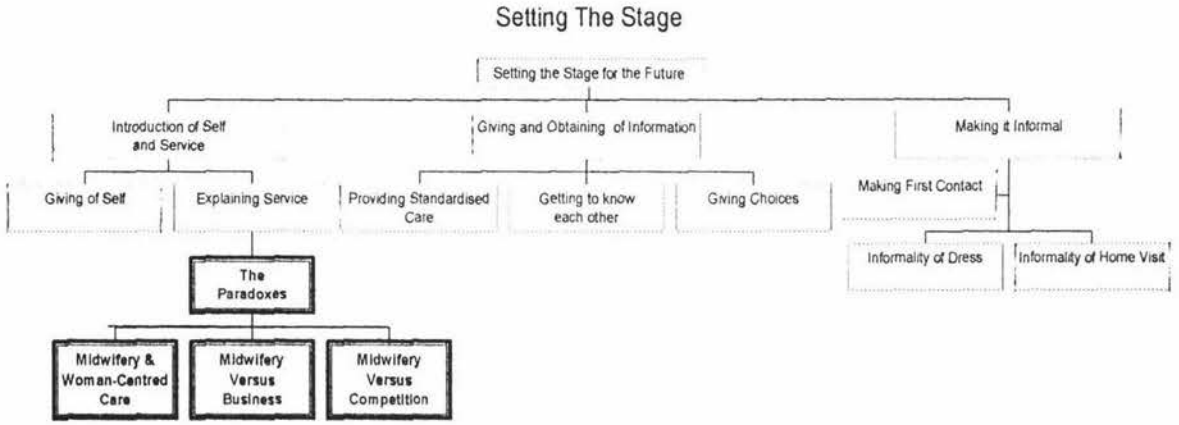
Since the initial bad press from the media, statistics are beginning to show that midwifery-only care is a safe option for women. According to the Ministry of Health (1998) statistics for 1995 the perinatal mortality rate in New Zealand has never been so low. The total perinatal death rate decreased in New Zealand by 29.9% between 1986 and 1995 when the latest numbers were available. The total perinatal mortality rate of 6.1 per 1,000 total births in 1995 was equal to the recorded low rates 1993 and 1994 (Ministry of Health, 1998). It is assumed from these figures that midwifery-only care, that commenced in 1990, has made a considerable contribution to the decline in the above mortality rates. Without being able to give accurate data on the percentage of births undertaken by independent midwives during that period it is not clear exactly what difference independent midwives have made. A demographic profile of self employed midwives in New Zealand developed by Guilliland (1996) recorded that the number of births with full midwifery care was 49.5% of the births in her sample. Auckland National Women's Hospital (1996, p.106), in their annual report, recorded independent midwives having 3.5% of bookings ending with a perinatal death. GPs recorded a figure of 7.7% of bookings ending in a perinatal death.

Throughout New Zealand GPs are ceasing to provide maternity care to women. One woman, reported in the New Zealand Herald (Masters, 1998), had contacted seventy-three GPs in a fruitless search for a GP to

deliver her baby. From July to September 1998 there were 451 GPs providing care, a drop from 845 in the same quarter of the previous year (The Daily News, 1998). In the same article Karen Guilliland is quoted as saying that more than 60% of women currently choose a midwife as LMC. If this is the case there will be fewer women choosing a GP and it may become difficult for GPs to keep their skills up to a safe level of practice. The midwives in the present study would refer women to the obstetrician if complications in the pregnancy arose in accordance with the National Referral Guidelines (Transitional Health Authority Maternity Project Team, 1997).

The part of the model presented in this chapter is outlined in diagrammatic form overleaf. "The paradoxes" are linked to the midwife explaining her service.

Setting the Stage: The Paradoxes
Figure 2



SUMMARY

The midwife is the person at the first antenatal visit who sets the scene for future care. This involves balancing the paradoxes that exist when the midwife attempts to deliver woman-centred care, run a business, deal with competition from the medical profession and an unfair payment system. Woman-centred care would seem to be one-sided with not enough consideration being given to the midwife. Self employed independent midwives with their own case loads provide an ideal service for women. This service is not without difficulties for midwives as they are on call twenty-four hours a day seven days a week. There is an imbalance between the payment received for this visit and the amount of time a midwife spends on the visit. To make it financially viable the first antenatal visit needs to be a lot shorter and an analysis of the benefits of home visiting needs to be undertaken. The final paradox that exists lies in the competition that exists between GPs and midwives. The payment system gives GPs unfair access to the midwife's budget resulting in the potential for antagonism between them.

These paradoxes have arisen because of the introduction of the Nurses Amendment Act in 1990 and changes to Section 51 of the Health and Disability Act (Health and Disability, 1993). This brought in a new way for midwives to deliver midwifery services and put them in direct competition with doctors. Few, if any midwives, were prepared for this transition. There were no well-defined guidelines developed to assist midwives in the transition from hospital midwifery to independent midwifery and certainly no guidelines instructing women on how to use the service. Midwives courageously left the hospital setting with little or no business knowledge and had to learn as they went along. Now nearly ten years after the introduction of the Nurses Amendment Act (1990)

this research has been able to identify some of the paradoxes that exist for the independent midwife in providing the first antenatal visit. In Chapter five the first antenatal visit will be examined from the pregnant woman's perspective.

CHAPTER 5

GETTING TO KNOW MY MIDWIFE

INTRODUCTION

The scene for the first antenatal visit has been set, the midwife's contribution explored and the paradoxes identified. There would be no scene without the participation of the pregnant woman. In this chapter the women's perspectives of the first antenatal visit are investigated.

OBTAINING INFORMATION BEFORE THE FIRST VISIT

Before getting to know the midwife there was certain information that pregnant women needed. Without the women taking these steps the first antenatal visit would not occur. Obtaining information involved confirming the pregnancy and seeking information on the availability of maternity services. The pregnant women all consulted a number of people before the first antenatal visit took place.

Confirming the Pregnancy

On missing a period the first information sought seemed to be the confirmation of a pregnancy. Women used a variety of familiar services to obtain a pregnancy test. Some women got a pregnancy test done at the family planning clinic.

> *Cause I went and got the test done at the family planning clinic by myself and I had to walk home and I bet you the people in their cars would be thinking what is that big grin on her face* (Donna, 1: 56).

Another woman wanted to go to the family planning clinic and get a specific person to do the test and be part of the enjoyment of sharing the news.

> *I just waited for about two weeks then I got tested. She sort of knew, like the last time I had seen her she was to update me with my pills and I said don't bother. She goes "I've got to do the test". So she sort of knew. She said "you are going to be parents"* (Jana, 1:34).

One woman went first to a private medical centre and got a negative result but visited her own doctor a few days later and got a positive result.

> (I) *went to the medical centre. I just went there and it was negative and about four days later I went to my doctor. I went to my doctor and that was positive* (Carol, 1: 69).

Another woman delivered a urine specimen to her GP surgery and phoned up for the results.

> *I just dropped in a sample in the morning and they said "stay and wait" and I said "no I can't, I've got to get my daughter to day care". I was meant to be working and I was actually really really busy and I umm rang them back at about eleven in the morning (pause) and they said "yep, it was a positive test"* (Karen, 1: 622).

Women's reactions to being pregnant varied. For some it was the feeling of shock, for others it was disbelief or joy.

> *I was just so excited* (Donna, 1: 56).

> *I just waited for about two weeks then I got tested. I was going to wait longer but it got the better of me* (Jana, 1:34).

> *She told me over the phone* (the results of the pregnancy test), *yep. I was just amazed (pause) I'd, I'd totally talked myself out of the fact that I might be pregnant* (Karen, 1: 622).

For one woman the need to confirm her pregnancy developed some urgency when she was told by a friend that if she wanted a specific midwife she had *"better make sure you get in early"* (Karen, 1: 68). All women in this study had a pregnancy test done before seeking midwifery care although pregnancy testing is part of the midwife's role.

Seeking Care

The seeking of maternity care was the first step for women to get to know their care provider. Women obtained information about maternity care from various sources.

> *My friend is actually pregnant at the moment and she's told me all about it* (Donna, FAV: 233).

> *I'd already talked to Peter* (husband) *about the fact that I would like to have Gloria* (the midwife) *again. And he was quite happy with that, so I already knew that, umm, my friend Jackie has Gloria at the moment, she's pregnant and I'd said to Jackie that, you know,*

we discussed it. This was before I was pregnant and Jackie said "look Gloria's really busy" (Karen, 1: 658).

Those women who had been pregnant before all knew they wanted a midwife to care for them in this pregnancy. They had gone through the process of seeking care with their last pregnancy but still had to find a midwife who was able to provide maternity services. One woman wanted the same midwife as in her last pregnancy because of the good relationship that she had experienced previously.

Basically as soon as I found out I was pregnant, well not as soon as, but once I sort of got on to about eight or nine weeks I thought I had better get on to her (selected midwife) *because I would hate her to be booked out. Well because we had such a good relationship you know and it worked so well* (Dot, 1: 32).

During her last pregnancy one woman's GP suggested she have shared care with an obstetrician. This did not appeal to the woman so she chose shared care with her GP and a midwife. Karen explained it by saying:

I went to him (GP) *when I was pregnant and he said "well as you know blah blah blah and I said what about a midwife?" And he was very anti at the time. And said that it was a first pregnancy and you never knew and blah blah blah and all the rest of it and so I came away from him feeling really uncertain about it. And in fact he was almost, like, to have shared care with a specialist okay, okay that was the option. And I came away from there and I actually had lunch with two midwives* (Karen, 1: 207).

One woman had shared care between a midwife and a GP with her last pregnancy but the midwife had subsequently moved out of the area.

She wanted midwife-only care this time but had difficulty in obtaining information about midwives.

> *She* (the practice nurse) *asked me if I wanted to go to my GP, specialist or what. I said I hadn't decided but I think I would like to have a midwife. She didn't actually give me any information. Even when I saw my GP two days later to discuss my options because I knew they had changed since my last pregnancy. He didn't give me a list either. I said I was thinking about a midwife but he didn't give me a list either* (Shona, 1: 25).

Not to be deterred this woman then phoned the hospital to get the information she needed to find a midwife.

> *Well I thought midwives work at the hospital, and surely I will be able to find out about the independent ones. I rang up and someone managed to get hold of some names for me* (Shona, 1: 42).

The reason these women were seeking midwife-only care was because of their past experience of having shared care with a doctor and a midwife. Having experienced maternity care from a doctor the women all chose a midwife to provide care in this pregnancy. The women believed that a midwife would be able to provide a different kind of service to that experienced in the last pregnancy.

> *The first visit with the other pregnancies were very brief as I was with a specialist. I decided to have a midwife this time* (Shona, 2: 57).

> *The difference between the visits with Gloria* (the midwife) *and the visits with the doctor were just incredible. I would go in and I'd be in and out of the doctor. The nurse would take my blood pressure and*

you know whatever and then I'd breeze in to see him and he'd have a wee poke and feel around and say yeah yeah fine and I'd maybe oh ten, ten minutes, you know ten minutes probably not even that with the doctor. A lot longer in the waiting room (Karen, 1: 308).

Having Gloria at home, it was more it felt like she was more involved (pause) and I say cared more umm (Karen, 1:377).

Dot and Karen go on to express their appreciation of the midwives who were with them during their last pregnancies.

The birth was just great. She (the midwife) *was just fabulous. It was part of the whole emotional thing you know* (Dot, 1:36).

She (the midwife) *was brilliant, brilliant* (Karen, 1:259).

For the women having their first child the steps towards getting to know their midwife were slightly different. Firstly they had to find out what to do. Women told me that they obtained information about antenatal care from the family planning clinic, friends or their GP.

I asked at Family Planning. They gave me a pamphlet on different midwives and the lady there said that Bridget was a good midwife and she did home-birth and hospital births which was what I would like cause I would like to have my options open. And so I rang her and made the first appointment and yes I am really happy with her (Donna, 1: 79).

Carol obtained her information *"through one of* (her) *mum's friends"* (Carol, 1: 105).

I went and saw my doctor (...) *mainly to see what to do. He gave me the name of some midwives* (Jana, 1: 63).

Patterson, Freese and Goldenberg (1990, p.29) in their study similarly found that "consulting with others - spouses, friends, colleagues, strangers - was one way many women gathered information about prenatal care".

Once the women had decided that they wanted a midwife the next step was to find a midwife who was able to look after them. For four women the first midwife phoned was available. For one woman the first midwife was unable to take her but the second midwife phoned was available. Another woman had to phone four midwives before a midwife was prepared to take care of her.

Because the focus of this study was on the first antenatal visit provided by an independent midwife, seeking midwifery care was part of all the women's experiences. For some women it was as simple as making a phone call. For other women seeking midwifery care was more complicated as they did not have access to the necessary information. Patterson, et al (1990) found that the process for obtaining antenatal care can be as brief as making a phone call to set up an appointment with an existing care provider but the process may also be more convoluted. Once telephone contact had been made with the midwife an appointment was organised for the first visit. The next point of contact between the woman and the midwife would be at the visit.

Pae (1994), in a New Zealand article believes that the care undertaken by a GP is continuity of care and is not possible in any setting other than general practice. It seems quite acceptable to this medical author that it is the practice nurse (who may or may not be a midwife) who

takes a history and explores some of "the myths and fallacies, fears and fantasies surrounding childbirth" (p. 77). It appears to be acceptable that it is the practice nurse who undertakes antenatal education. The women in this study who had experienced care as described by Pae had decided not to have a GP involved in the present pregnancy care.

FOLLOWING THE MIDWIFE'S LEAD

Once the midwife had successfully engaged a midwife the first antenatal visit was organised. At the visit the midwife set the scene, decided the content and structure of the visit and decided when to terminate the visit once she had completed all her tasks as outlined in chapter three. Although the visit was generally directed by the midwife, the women were neither passive nor non responsive to the way in which the visit was standerdised and the process of the visit

Responding to the Home Visit

The benefits for women having the first antenatal visit in the home included no waiting time, no need for child care and a more convenient appointment time. These benefits overcame the barriers to accessing institutional antenatal care identified by Maloni, Cheng, Liebl, and Sharp (1996).

There was a very positive response to the first antenatal visit being held in the woman's own home. For one woman a home visit was important because she felt it allowed the midwife to know her better and for her to get to know her midwife. This woman saw a home visit as friendly. At this visit there was a lot of laughter both by the midwife and the woman. Their relationship was well established as this same midwife

had attended this woman during her last pregnancy. Karen explained the home visit by saying:

> (Having a home visit) *was really important, it was really nice to have Gloria to come into the house because I felt that she knew me a bit more rather than yeah it was a two way thing yep.(...) I don't know it was just friendly, a lot friendlier yeah it was easier for me I think because it was my, it was my territory. You know so it felt secure for me* (Karen, 1: 353).

Having little children could cause problems in keeping appointments if the visit was not held in the woman's home. At the two visits where children were present they were running around, playing with their toys, reading their books and cuddling into their mums. Both the mothers and the children were in familiar surroundings.

> *This is really important to me. I have two little children and there is often one of them sleeping. Getting to appointments with little children is really difficult. I feel relaxed in my own home* (Shona, 2:114).

The woman who went to the midwife's home was asked about the visit in the midwife's own lounge. She described it as:

> *Scary. Strange. But after a while I felt comfortable, I suppose. Going into somebody's else's house when I haven't met her before was strange. I would like to have known about what she does and stuff when you go* (Carol, 1: 207).

Carol, when asked if she would have liked the antenatal visit to be in her own home replied:

It didn't really bother me but I probably think that would have been better (Carol, 1: 213).

As an observer, it seemed that the woman was less relaxed in the midwife's home as she sat on the edge of her seat throughout the whole visit. Not knowing what to expect did contribute to this nervousness.

Waldenstrom and Nilsson (1993) noted that the home offered the greatest possibility of satisfying the women's need for control. The expectant parents are the hosts, the midwife the guest and the relationship between them is shaped accordingly. Methven (1990) believes that the advantage of the woman's home environment is that the woman is more relaxed. She may also have access to information required by the midwife that she would not have thought to bring with her to the hospital or a clinic.

It was possible to make some comparisons between the first antenatal visit being held in the women's home and a woman visiting the midwife's home. The visit in the midwife's own home was the shortest visit, lasting only forty minutes and had fewer interruptions.

In a partnership model of midwifery both the midwife and the woman need to be involved in deciding on the best place to hold the first antenatal visit. The process of getting to know the midwife appears easier in the woman's own environment as noted by Waldenstrom and Nilsson (1993).

Responding to the Process Information Exchange

The main part of the first antenatal visit, and that which took up the most time, involved the giving and receiving of information. This was led by the midwife and has been described as the midwife providing standardised care in chapter three. During the first antenatal visit the way in which the midwife asked the woman questions resulted in a question and answer session. This influenced the way in which women answered.

> *Any blood transfusions?*
> *No.*
> *Are you allergic to anything that you know of, any drugs or plasters or whatever?*
> *No.*
> *Do you suffer from asthma or eczema?*
> *No.*
> *And your smears, are they up to date?*
> *Yep.*
> *You've had all normal smears?*
> *Yes.*
> *Do you smoke?*
> *No.* (Midwife Dana and Jana, FAV: 220)

The women were all presented with a large amounts of information. I will only give one example of this to illustrate the point that women listened and midwives spoke.

> *On the back and that's what I was saying, put it in an important place, on the back it covers when to contact me and how to contact me. It says when labour begins but that is talking about labour at a*

normal time in your last month of pregnancy. At the minute you need to know that you should contact me straight away if you have any bleeding, or your waters broke, if you went into labour early if you have any of these problems like long headaches, long vomiting, urine problems and more particularly with you we would be looking at that. If you thought you had a urine infection or anything like that. Or any unexplained or severe pain. Also once you are feeling your baby move which will be a bit further down the track once you know what is normal for your baby's movements if your baby doesn't move that day then you should give me a call. But I will be talking about that again later. Basically if you are worried about something you should call me. And I would always rather that you did than that you fretted for a month till the next visit when its something we could have easily sorted out over the phone. Basically don't hesitate to call. Also if you are worried about how she is (the baby). *How you do it. The first step is to call me at home which you have done already, if I am not at home or if I am not answering the phone if it is nothing at all urgent you can leave a message on the answer phone so that might look "I've discovered my appointment is in a fortnight I have to change it". That is fine leave it on the answer phone. But if it ever involves you or your baby being unwell or anything to do with labour, don't leave a message on the answer-phone because sometimes if I have had a long day I don't get in, like the other night I got in at ten o'clock at night after a meeting actually and someone had left a message and it is like. Do I ring and wake her up or is it all right or how bad is it you now like just that she wasn't well and I didn't know and I fretted all night wondering how unwell she was. She was actually fine and that is why she hadn't paged but I probably rather you actually paged if it was anything about not being well. That way I am free to be out and about to socialise or working and you can still get a hold of me that*

> *is how you get a hold of me is with the page. So if it is nothing urgent at all you can leave a message. Otherwise you page me. Do you have toll bar on your phone* (Midwife Bridget, FAV: 793).

After all this information was given to Donna her only reply was "No" (Donna, FAV: 830) before the midwife went on for another 1,500 words with the pregnant woman only saying three more words of "OK", "Yep" and "OK". This was the general pattern of the first antenatal visit for all of the women involved in the study. Women responded to this information in different ways.

Being Overwhelmed

Women regard pregnancy and childbirth as significant episodes in their lives and may be experiencing mixed emotions entering the first antenatal visit. Dot reflected on her last experience:

> *Oh pregnancy and the birth was just fantastic. Not fantastic in a really groovy way but it's such a big experience, a huge experience.* (Dot, 1:9).

For other women, the first antenatal experience was unnerving.

> *It was nerve racking. I don't know, just new I suppose. Next time it will be fine* (Jana, 1: 8).

> *I was quite nervous. I don't know. Just it didn't feel real* (Donna, 1; 113).

> *Scary. I didn't know what to ask or anything* (Carol, 1: 136).

A variety of comments were forthcoming when the women spoke about the first antenatal visit and the amount of information provided.

> *It wasn't that bad after all* (Laughter) (Carol, 1: 290).

> *It wasn't overload as such but I was surprised because my friend was actually pregnant and I was asking her what was her first antenatal visit like and she was saying that she was disappointed because it was over like that* (snaps fingers) *and it was nothing like she expected it to be. So I was expecting it to be over in ten minutes and when we went on for two hours I was really impressed* (Donna, 1: 149).

> *I was surprised. I didn't think it would go for that long* (Dot, 1:56).

> *Got excess information in terms of things to read* (Karen, 1: 1005).

> *It was overwhelming. You can't take it all in* (Shona, 82).

Although overwhelmed by the information being given to them, women were getting to know their midwife throughout the information sharing experience. The giving out of information could appear to be seen as routine rather than tailored to meet individual women's needs.

Focusing on the now

Women were looking for information that they needed to deal with their present situation. They wanted encouragement, information on morning sickness and how to have a healthy pregnancy. When asked what information she wanted one woman having her third pregnancy replied:

> *I wanted reassurance. I wanted to know if we were going to get on* (Shona, 2: 89).

Yet another woman was quite satisfied with the information that she received.

> *I learned a lot. A lot of the stuff I knew already but I was really happy with all the information she gave me. A lot of options* (Donna, 1: 158).

Those women suffering from morning sickness wanted to receive information about how it could be managed. This was important for Karen.

> *Umm, I did read the stuff that she had there on morning sickness. I did read through that* (Karen, 1: 1028).

> *Yeah this time I read the pink sheet about the remedies* (for morning sickness) *there. That's probably my main things at the moment to get through* (Dot, 1: 69).

Donna summed up what information she wanted:

> *Mainly just how to look after myself, have a healthy pregnancy. Avoid things like alcohol, smoking. I don't smoke and alcohol that is fine that is no problem to give up. It is looking after myself really* (Donna, 1: 331).

Karen, discussing what information she wanted, said:

I'm just trying to think, I did have a look at the stuff on the scans but I was too tired so I just thought I'd put those aside and make a decision on another time

Information on the scans was less important and could wait to be read later. This was a benefit of having been provided with written information in that even if women did receive large amounts of information at the first antenatal visit, they could revisit the information at a later date.

It was not the aim of this study to investigate what information women needed or wanted at the first antenatal visit. However from the data it would suggest that information most important to women in early pregnancy is on how to look after themselves at present, including managing morning sickness. All women received information that dealt with the issues facing women in early pregnancy but they also seemed to be overwhelmed with additional information which was not relevant at the time.

GETTING ACQUAINTED

Getting acquainted involved summing-up the midwife and reflecting on past pregnancies. This process was different for women who were pregnant for the first time than for those who had experienced a pregnancy in the past.

Summing-up Their Midwife

Holding the first visit in a home environment gave women the opportunity to sum-up the midwife in a relaxed environment. As the

antenatal notes were being filled out women were assessing the midwife and the situation. A dictionary definition of summing-up states that it can be a review of the leading points (Macdonald, 1978). Many issues assisted women to sum-up their midwives and identify key points to assist women in making a judgement about the midwife and getting better acquainted with her:

Following the first antenatal visit Shona commented about her midwife that she:

> *felt confident with her and had confidence in her* (Shona, 2: 101).

> *I thought she* (the midwife) *was nice. She was smiley and bubbly* (Jana, 1:19).

Women assessed that the midwife was knowledgeable and that she was a person that was prepared to give of her time. Women were impressed by this. Being "smiley" and "bubbly" was important to Jana. This was Jana's way of summing-up the midwife. Pregnancy for Jana was a happy event and it was important for her to have someone who could reflect that feeling. Being happy tells little about the professional care being delivered but does inform women that the care being delivered would be conducted in a relaxed and positive atmosphere.

Women who had the same midwife with the last pregnancy had already summed her up and therefore because of their previous experience they again chose the same midwife.

> *She was just fabulous. I mean she was special because she was there* (last pregnancy) *you know* (Dot, 1: 53).

Other peoples opinions were also important in the summing-up process.

> *I'd heard things from other people in town about the midwife. I have utmost confidence in Gloria* (Karen, 1: 873).

Karen identified her midwife's leading points:

> *About Gloria, she is (pause) well she's got a good sense of humour, she's pretty practical. She (pause) what do I like about her, she was really supportive* (Karen, 1: 1172).

Donna was impressed by her midwife's knowledge and summed her up by saying:

> *Bridget was really well informed. She was very good at everything, quite overly actually* (Donna, 1: 138).

Finally being "normal" was an important asset for a midwife to possess.

> *She is lovely. I really like her. She seems like a normal person. I really sort of related to her. I didn't feel intimidated or anything* (Donna, 1: 189).

Normal meant that the woman was not frightened by the midwife and she felt comfortable with her. It is likely that the midwife was the kind of person that Donna was used to communicating with and felt relaxed in an informal situation.

The participant who had the first visit in the midwife's home still wanted to "get to know" the midwife before she could be certain about how she felt about her.

Once I get to know her I think she will be easy to talk to (Carol, 1: 265).

The process of summing-up the midwife can be instantaneous or, in Carol's case, it may require more time. Different women had different criteria for summing-up the midwife but what did seem important was that the women liked their midwife.

Women in Pairman's study (1998, p. 5) summed up the midwife using terms such as "supportive", "human", "good listener", "knowledgeable" and "competent". It is assumed that summing-up process may continue throughout the pregnancy. In Fleissig's (1993) study women were noted to sum-up staff as being kind during the birthing process. I was unable to find any more data to substantiate this.

Reflecting on Past Experience

Part of the first antenatal visit for women with their second or third pregnancy involved women reflecting on their past experiences and the summing up that had taken place previously. They already knew their midwife but seemed to use reflection for reconnecting with the midwife.

Actually it was quite nice to talk about the first birth (Dot, 1: 22).

Like the last time, last time was good, I agree it was really good right up until pushing. The pushing, and pushing and pushing and pushing (Karen FAV: 228).

Oh the thing is it was compounded last time because I got that Streptococcal infection which didn't heal, that was it and that's the

reason why I don't want to stay in hospital I want to leave as soon as, I mean, yeah, I don't know what you think (Karen, FAV: 543).

Women who had had previous pregnancies were more talkative during the first antenatal visit and were able to contribute more to it. I counted the number of words spoken at the interview between the midwife and the woman and found that women with previous pregnancies spoke around 24% of the time compared to first time women who spoke for around 6% of the whole visit. Turned another way, midwives took up on average 94% of the conversation with women having their first pregnancy and 68.5% of the conversation with the others. Much of the extra conversation undertaken by the women who had experienced pregnancies was the reflection on their last pregnancy.

I remember having her Monday night and I came home on Thursday afternoon. I was still a bit nervous about, you know, the baby and how I would cope afterwards. Remember you said something to me about one or two weeks after something like it's not that hard really. I only remember three things, she's (the baby) *either wet, she's hungry or she's got a pain in her tummy. That reminded me of the post natal time when it wasn't as hard as you thought it would be. This time it's a bit harder. So I think I was just scared because it's the unknown and at the end of the day it was, she was good. She either slept or she was awake or she had a feed* (Dot, 1:159).

It was probably the most depressing thing about being pregnant was seeing them (legs) *grow. I remember just sitting on the bed and crying my eyes out. Look at my legs* (Dot, 1:585.).

Known Midwife

Summing-up allows women to formulate opinions about their midwife and get to know their midwife better. All the women responded positively to the midwives and it was probable that it would be the same midwife who would care for the woman during pregnancy, birth and the post natal period. Knowing their midwife was expressed as continuity of care which was regarded as important for some women.

> *I wanted my midwife umm the continuity of care. That was the main thing for me and also because at the labour I wanted to have the same person there, not my doctor who may or may not be there* (Karen, 1: 233).

Later on the same woman said:

> *I think the biggest thing for me was that, is that if I'd had a doctor, I think if I'd gone with the GP then I wouldn't have had anyone to help me with all the breast feeding problems and to me that just sums it up* (Karen, 1: 460).

Two pregnant women said:

> *I wanted the same midwife in labour. I wanted continuity of care. This was definitely important* (Shona, 2: 62).

> *I want her to be my midwife for the whole time* (Carol, 1:265).

Dot wanted the same midwife who had cared for her in her last pregnancy to be involved in this one. This was because she felt she

knew the midwife and this was important. They had developed a good relationship and Dot felt that she was her midwife.

> *... because we had such a good relationship you know and it worked so well, I don't mind having anybody else and going through the same thing as building up the relationship but if it's already there* (...) *she was special because she was there you know. She was my own midwife* (Dot, 1: 36).

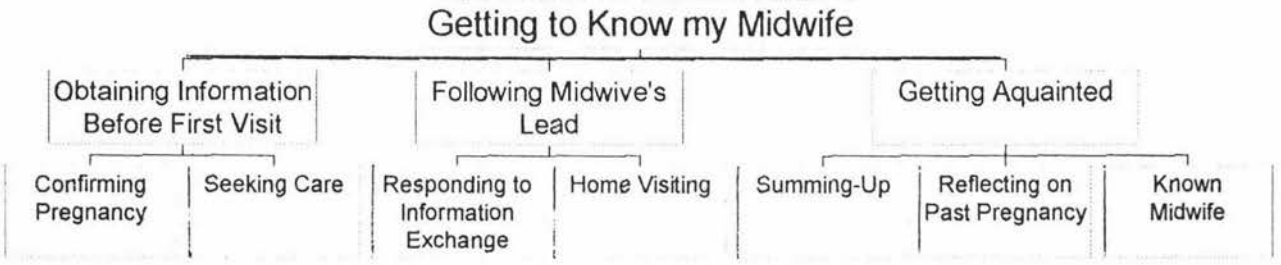
Some authors view continuity of care as meeting client's specific needs

> Women have been asking for the same people to be involved in their care all through pregnancy, labour and the post natal period for years. Women want and need us to provide continuity of care - when we make no effort to provide this, it signifies that we are not listening to our clients and we are not providing the service they are asking for (Cronk & Flint, 1989, p.48).

The independent midwives, in the present study, provided continuity of care to pregnant women. Women who experienced this continuity in the past valued it and regarded it as one of the main reasons for seeking midwifery-only care now. Some women who were pregnant for the first time were aware of wanting the same midwife for the antenatal, birth and post natal periods. Continuity of care means that when a woman goes into labour the midwife will be well known to woman. The midwife will be "her" midwife. It is during the first antenatal visit that women begin to get to know their midwives.

The part of the model presented in this chapter is outlined in diagrammatic form with getting to know their midwife now for the future through continuity of care, reflection and a process of summing-up.

Getting to Know My Midwife
Figure 3



SUMMARY

Getting to know their midwife was the main concern for the women during the first antenatal visit. Confirmation of pregnancy and seeking of care was the prerequisite to getting to know a midwife. Women followed the midwife's lead throughout the visit and responded positively to the home visit setting. Although the women were overwhelmed by the amount of information given out, they were impressed by the midwife's knowledge base. The main information required by women at the first antenatal visit related to their present health and, where necessary, information on morning sickness. Getting to know their midwife involved getting acquainted. This process included summing-up the midwife and reflecting on their previous pregnancies and meant that they would have a known midwife with them during pregnancy, birth and the post natal period. All women were happy with the midwife they had chosen and regarded continuity of care as important. In chapter six a descriptive model of the whole process undertaken by the midwife and the woman will be presented and an audit trail will be given.

CHAPTER 6

MEETING NOW FOR THE FUTURE

INTRODUCTION

This brief chapter will bring all the data analyses together within one descriptive model. This includes the categories of setting the stage, the paradoxes and getting to know my midwife and will be depicted in diagrammatic form. An audit trail will be provided to give more credibility to the model.

MEETING NOW FOR THE FUTURE

The midwife and the woman meet at the first antenatal visit. This is an opportunity for the midwife to ***set the stage for future*** midwifery care. She gives information regarding early pregnancy, birth and the post natal period and fills out the antenatal notes in preparation for the pregnancy and the birth. The stage is set as an informal rendezvous where the woman is given information to allow her to make choices in the future.

The pregnant woman is following a completely different process at the first antenatal visit to that of the midwife. For the woman there is a process of ***getting to know her midwife*** which begins before the first visit. The woman first confirms her pregnancy before seeking care and contacting the midwife by phone. This process of getting to know her midwife will continue from the first antenatal visit through pregnancy, birth and the post natal period.

Both the woman and midwife are coming together ***now for the future*** but the reason for coming together is different for each. It is the midwife who is the main character on stage and the woman seems happy to follow the midwife's lead. As was found in Olsson, Sandman and Jansson's (1996) phenomenological study, the midwife seemed to be the one who determined the content and the way of relating that dominated the antenatal visit.

The basic social process (BSP) in this study is the same as the core category of "meeting now for the future." A BSP does not mean that "meeting now for the future" is the only aspect of theoretical importance in the first antenatal visit. The only claim being made is that "meeting now for the future" explains much of the variation to be found in the action, interaction and perception found in the data collected from the research site (Glaser & Strauss, 1967). A BSP is a theoretical statement about process which can occur in other areas of social life as well (Glaser & Strauss, 1967) and was found to occur at the first antenatal visit.

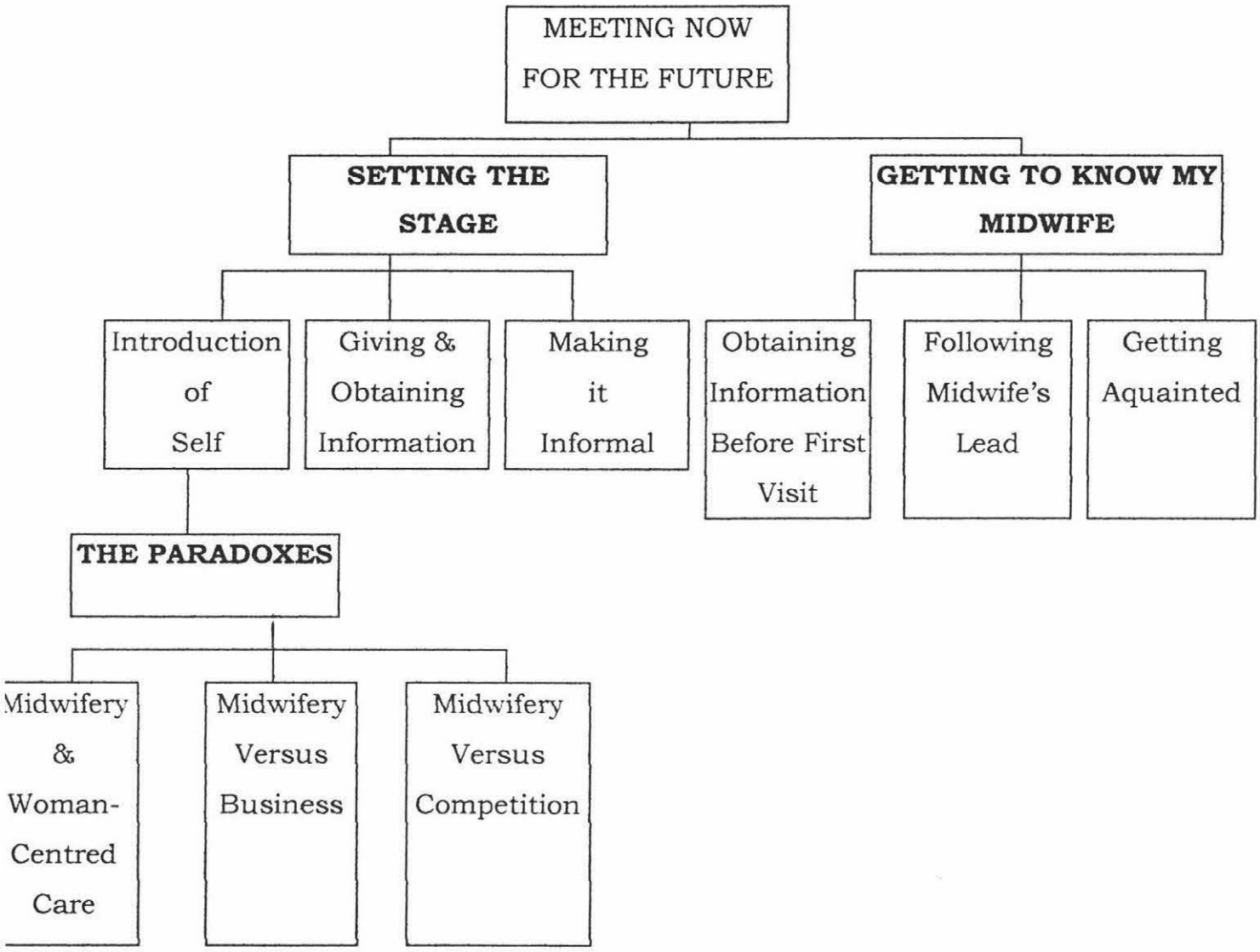
Although the BSP has been identified, midwives and women are sill undergoing different processes and there is a need to define the objectives of this crucial first visit. Is the objective of this visit for the midwife to set the stage for future care or is the objective for the midwife to meet the needs of the women? To meet the needs of women midwives may consider concentrating on informing women about themselves and their service and give women only the information they require at this time in pregnancy.

The whole descriptive model that has emerged during this study will be outlined in diagrammatic form overleaf bringing together the process undertaken by the midwife and the pregnant woman at the first

antenatal visit. The whole model is constructed as " Meeting Now for the Future".

FIGURE 4

MEETING NOW FOR THE FUTURE



THE AUDIT TRAIL

An audit trail will assist to authenticate the model and give understanding to its development. Analysis of the data took the form of that described by Glaser (Glaser & Struass, 1967; Glaser, 1978; Glaser, 1992).

I started off by open coding the data contained in the transcriptions of the interviews, the fieldnotes, memos and the visits. This initially produced a plethora of different ideas. Codes such as health promotion, form filling, options, future planning, negotiating, overloading, women's rights and more were uncovered. As a novice it took a little time to see what was coming from the data but gradually codes did emerge. These codes can be seen in the table below.

CODES

Alternative therapy	Assumptions (no fit)	Balancing
Business	Choosing a midwife	Continuity of care
Decisions	Excess of information	First antenatal visit
Getting test done	Information gathering	Information required
Information sources	Overwhelming	Involving others (no fit)
Reflecting practice	Pre antenatal	Reflect on past pregnancy
Summing-up	Home visiting	Competitions
Sameness (no fit)	Midwife supervision	Offering self
Midwife domination	Casual dress	Philosophy
Relationship		

I kept on asking myself "what is this a study of?" "What is happening here?" as I analysed the data line by line. Through the constant comparison method patterns of similar incidents were identified and grouped together as categories of "Setting the Stage: The Paradoxes, "Getting to Know My Midwife" and finally "Meeting Now for the Future" seen in the tables below.

CATEGORIES & CODES

1 "Setting The Stage"

Alternative therapy	Midwife domination
Excess of Information	Offering self
Information gathering	Casually dressed
information required	home visits
Sameness	Relationship

2 "Setting The Stage: The Paradoxes"

Balancing	Business
Philosophy	Competition

3 "Getting to Know My Midwife"

Choosing a midwife	Decisions	Information required
Overwhelming	Continuity of care	Reflect on past pregnancy
Getting tests done	Information sources	Summing up

By going over and over the data, the categories that first emerged were "setting the stage" and "getting to know my midwife". I knew from the data that there were several paradoxes apparent but did not know how they fitted in with the rest of the codes and categories. I tried them as a separate category but that was not appropriate. Then on closer

examination I found their rightful place to be within the category of "setting the stage".

"Setting the stage" came from Midwife Cath's own words as described in the chapter four. "Getting to know my midwife" took a little longer to identify as the women described wanting the same midwife or asking for continuity of care as seen in Chapter Six. It took greater thought and discussion to really discover what was going on here.

Quite early on in the data collection I thought I had discovered the core variable to be "overwhelmingly informative". The amount of information being given out to women as stated in the data chapters was "overwhelming". On further data collection "overwhelmingly informative" was not the core variable as it really only affected the woman and did not describe a process that women were actually involved in. The next core variable that was proposed was " setting the stage" and although closer to the final core category did not completely fit with all the participants. It was the midwife that was setting the stage not the woman. Finally the core category to emerge was "meeting now for the future" and on further data analysis, spending time thinking and writing ideas, I found this to fit well. This final model was discussed with an independent midwife who was not a participant and who had recently resigned to take up a post elsewhere. She was happy with the final analysis. I then contacted one of the pregnant women and discussed my findings with her and she was also in agreement with the findings as they related to herself.

THE CORE CATEGORY

"Meeting Now For the Future"

Setting the stage	Setting the stage: The Paradoxes
Getting to know my midwife	

The descriptive model that is presented is a group of interrelated concepts that fit together because of their relevance to the first antenatal visit. The descriptive model encapsulates the process being undertaken at the first antenatal visit by the midwife and the woman.

SUMMARY

Midwives and women are meeting now for the future but the process being undertaken by the midwife is different from that being undertaken by the woman. The midwife is setting the scene for the future while the woman is wanting to get to know her midwife. In chapter seven the first antenatal visit is re-examined in light of this research.

CHAPTER 7

DISCUSSION AND RECOMMENDATIONS

INTRODUCTION

Within this research of the first antenatal visit, what is happening between the independent midwife and the woman has been explored. Grounded theory, as the research methodology, has been used to conduct the research and finally encapsulate the experience of the first antenatal visit within a descriptive model. The core category, which is also the BSP, emerging from this research is "meeting now for the future".

Although the number of participants in this study was small, each participant provided meaningful insights into the happenings at the first antenatal visit. A number of implications for midwifery practice, education and research arose from the participants' stories, the observations and the data analysis. These implications, combined with recommendations are discussed as are the limitations of this research.

IMPLICATIONS FOR MIDWIFERY PRACTICE

The core category and the BSP that emerged from this study is that the first antenatal visit is *"meeting now for the future"*. As has been described in the data chapters, meeting now for the future is multifaceted and involves spoken and unspoken communication. If "meeting now for the future" is the main element in the first antenatal

visit, then how the visit is conducted needs to be considered by midwives.

Midwives and women are seen to be undertaking two different processes at the first antenatal visit. Midwives are providing the first antenatal visit in an informal environment and *setting the stage* for future care. They are giving women a large amount of information, much of which they may not need, or be able to absorb. Midwives are preparing the antenatal notes for when these women go in to hospital to give birth. Continuity of care allows meetings with the same midwife, thus notes can be completed later rather than at this first antenatal visit.

For women the main process being undertaken is *getting to know my midwife.* This starts before the first antenatal visit and develops through time with continuity of care. One mother wanted no information but was looking for reassurance and continuity of care. Some women wanted information on morning sickness, antenatal classes and staying healthy during pregnancy, information that was relevant to that stage of pregnancy.

There is a need for midwives to assess what is happening at the first antenatal visit and to review their practice according to the needs of the women they serve. Each woman needs to be treated individually. Guilliland and Pairman (1994, p.42) state that "each woman brings with her a unique set of characteristics and circumstances" and that " the midwifery service is dictated by each woman's identified needs". With a reduction in the amount of information given out and postponement of completing the antenatal notes, the first antenatal visit could be considerably shorter. This shorter visit could be more cost effective for the midwives delivering a service in a business environment and possibly become more woman-centred.

Home visiting was found to be time consuming for the midwife but women were overwhelmingly in favour of the midwife visiting them in their own home. A cost benefit analysis of the situation would be able to address this issue and assist midwives in deciding whether to continue with home visiting.

In the region under study midwives are working extremely hard to provide good maternity care. Delivery of good maternity care which is compatible with the midwifery philosophy as stated in the Midwives Handbook for Practice (NZCOM, 1993) is time consuming and difficult when midwives are trying to run a profitable business and deal with the competition of the GPs. Midwives need to find a balance in their work and deliver the service that is required at the time.

Running a business and delivering good maternity care can cause problems for the independent midwives. A review of the payment system needs to be undertaken that reflects the time-consuming process of providing woman-centred care. The payment system adds to the problems midwives encounter with some medical staff. GPs should not be able to access money from the midwives' own fund without the permission from the midwife. Midwives need to lobby for a better payment arrangement as there is a need to be able to overcome the difficulties encountered in this area.

Midwives were found to have difficulty in dealing with the day-to-day business side of their practice. Clerical assistance would be able to relieve the midwives of these tasks and allow them to concentrate more on what they know best.

Working as caseload independent midwives placed added stress on these midwives who were on call twenty-four hours a day seven days a

week. Although there was a loose arrangement for cover with other midwives this gave little chance for midwives to have time off. Team midwifery as described by Flint (1993) may be something that midwives may wish to consider in the long term. This would still allow for continuity of care but allow midwives to have more free time with cell phones and pagers turned off.

IMPLICATIONS FOR EDUCATION

From this study the midwives identified their lack of knowledge in the area of running a business. Midwives identified that the amount of paperwork and administration being undertaken was excessive and this involved form filling just to be paid, GST and tax returns as well as collaborating with doctors, ordering scans and tests and following up on each visit when necessary. Midwives identified the need for knowledge in these areas. I contacted one tertiary provider of midwifery education to investigate what course content there was on business practices. I was informed that it was provided as an elective option to student midwives. I would suggest that this should be a compulsory part of the student midwife's programme. There is a need for extra-mural courses on running a business being made available for those midwives already in practice, or those considering becoming an independent midwife.

The issue of safety for the independent midwife undertaking a home visit although not part of this study was identified by me as I was recruiting the participants. The first pregnant woman who showed an interest in the study was involved in an abusive relationship. On going to discuss the study with the woman it was disclosed very early to me that this woman was abused. When the husband came home I engaged him in conversation but I became very uncomfortable and felt unsafe. It was decided, in consultation with my supervisor, that I not be put at

risk. As the appointment time for the first antenatal visit was changed by the midwife the woman was informed that I was unable to make this new appointment. I was informed by the woman that social services were involved with the family. I asked if I could inform the midwife of the situation which I did.

IMPLICATIONS FOR FURTHER RESEARCH

"The best research is that which breeds more" (Oakley, 1992, p. 9). This research has specifically focussed on the first antenatal visit between the independent midwife and the woman. The stories were previously unknown. It was therefore necessary to undertake preliminary research that was tightly focussed and which could provide a base on which other studies could develop. Many more questions than answers have emerged from this research.

This study involved both women who were pregnant for the first time and women who had already given birth. There was some beginning data from this research to suggest that the needs of these two groups were different. The different needs of these two groups have not been researched within the New Zealand context.

A potential research question arising from this research could be "is the care that midwives are providing at the first antenatal visit the most appropriate"? This would bring to light for practitioners and women what the structure, content and length of the visit could be. If this information was distributed to women the fear of the unknown as experienced by participants in this study could be averted. This would also inform practice and guide midwives in the future, allowing them to deliver evidence based practice for the benefit of themselves and the women and delivering a quality improved service.

There are other questions that need to be explored to provide a wider perspective on the first antenatal visit. These include an analysis of different types of services being provided by midwives, doctors and specialists and the satisfaction of women receiving the different services. There was some suggestion from the women that the care being provided by the self employed independent midwives was better care than that being provided by doctors. If this is the case then it needs to be supported by research.

LIMITATIONS OF THIS STUDY

It must be acknowledged that there are limitations to this research. Artificial temporal boundaries were placed on this study, by its nature as a piece of academic work. This resulted in a number of limitations as to the sample size, theoretical sampling and breadth of geographical location involved in this research. If other geographical sites had been included this would have been time consuming and complicated as it would have involved other regional health authorities and their ethics committees. The imposition of an artificial time frame of undertaking a thesis in one academic year also prevented a more in-depth study. Although there was evidence that saturation (as described in the methodology chapter) was beginning, further observations and interviews would have confirmed this more clearly.

Although the process of theoretical sampling was utilised, access to other midwives and women or even other similar situations involving GP and family, or student and supervisor, could have led to the emergence of different codes and altered the data analysis had time not been limited. In a grounded theory study it is the general rather than the specific applicability that is important. The acceptance of this research

by the participants and other midwives as being generally representative of their experience helps make this research credible.

The participants involved deserve and require total anonymity. The need to safeguard the midwives and women in this study has occasionally meant that identifying details that may have enlightened the reader about different midwifery practices have been omitted.

With a constant focus on the emergent data analysis, research decisions were made, such as how theoretical sampling would be undertaken. Although these decisions flow from the data they are ultimately personal and subjective decisions with the power to change the focus of the research at any point.

To obtain credibility or truth value in qualitative research it is important to take the data and interpretations back to participants. Sandelowski (1986, p.35) believes a qualitative study is verifiable if it reveals accurate descriptions of individuals' experiences and "that the people having the experience would immediately recognise it from the descriptions or interpretations as their own". This study has been discussed with both women and midwives involved in the study. All agreed with its findings as it related to themselves. I also engaged one midwife who was not involved in the research to read and comment on the research. Her opinions were greatly valued.

It is impossible to deny that my own personal interest and experiences as a scholar and a midwife have helped shaped this research. I have constantly questioned my own stance and have attempted to raise underlying assumptions that have developed from those experiences. Deep down I wanted to discover that the core category underpinning the first antenatal visit was the development of the midwife/woman relationship. This was not to be. I believe that my own experiences

provided me with a sensitivity and starting point that enabled rather than directed this research.

CONCLUDING STATEMENT

This study used the methodology of grounded theory to explore the experiences of the independent midwives and pregnant women at the first antenatal visit. Twelve women participated in this study providing the means whereby the experiences of the participants could be depicted and developed into a descriptive model.

The study has shown that the midwife and the pregnant woman are undertaking two different processes at the first antenatal visit. The midwife is setting the stage for future care and the pregnant woman is getting to know her midwife for the future.

Independent midwifery faces many challenges now and in the future. It is hoped that this research will assist midwives to look at their practice and make any changes that they see fit.

APPENDICES

APPENDIX A

TYPIST CONFIDENTIALITY CONTRACT

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Facsimile +64-6-350 5668

COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

TYPIST CONFIDENTIALITY CONTRACT

I ..... have accepted the task of word processing the research data collected by Mary Sylvester in order to complete an M.A. (Midwifery) at Massey University.

I understand that the data gathered for this research is confidential, and I agree to take all necessary steps to ensure that any material on audio-tape or computer disk containing data from interviews relating to the research will be:

a) Heard only by me, and transcribed to disk in private
b) Stored safely until returned to the researcher
c) Treated as confidential.

Signed

.....

Witnessed

.....

Date

.....

APPENDIX B

LETTER OF INTRODUCTION

MASSEY
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COLLEGE OF
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SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

LETTER OF INTRODUCTION

Research into what happens between the independent midwife and the woman at the first ante natal visit

My name is Mary Sylvester and this year I am completing my Master of Arts Degree by undertaking research into the first ante natal visit. My research supervisors are Dr Cheryl Benn and Lesley Batten both lecturers at Massey University. I am a Nursing Tutor at (Named) Polytechnic and have taken one year of study leave to complete this project.

I would like to invite you to consider participating in this research. I would like to observe what happens at the first ante natal visit and interview you afterwards. The interviews would involve one or two interviews of 1 to 1½ hours each at suitable times from April to July 1998.

If you wish to consider taking part in this research, or would like to hear more about it, please contact me by phoning (Code) 758 3401.

If you have any questions regarding this research you may contact

- Dr Cheryl Benn School of Health Sciences, Massey University, Tel (06) 350 4332
- Lesley Batten School of Health Sciences, Massey University Tel (06) 350 4323

APPENDIX C

INFORMATION SHEET

(WOMEN)

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SCHOOL OF
HEALTH SCIENCES

INFORMATION SHEET (WOMEN)

Title: What happens between the independent midwife and the woman at the first ante natal visit

Researcher: Mary Sylvester, Massey University Student, Struan House, 95 Gover Street, (City). (Code) 758 3401

You are invited to take part in a research study to examine what happens at the first ante natal visit for this pregnancy. This research is being completed as part of the requirements of a Master of Arts degree.

At the independent midwives meeting I will inform the midwives of the study and invite them to participate. You will initially be approached by your independent midwife, when you first make contact with her. I would like to talk to about 10-14 participants (women and midwives) and be present at your first ante natal visit. If you agree to participate you will be asked to sign a consent form. The interviews will be held either at your home or at a place nominated by you. After observing the first ante natal visit I will interview you within two weeks.

Thereafter, if necessary and further information is needed, one further interview will be held. The ante natal visit and the interviews will be audio-taped with your permission, to allow transcription of the data. Each interview will last between 1 - 1 ½ hours. You may request that

the tapes be returned to you, otherwise the tapes will be stored in a secure place for five years then destroyed.

Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part you will receive the usual care from your midwife. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your future care.

You have the right at any time during your participation

- to ask any question about the research
- to refuse to answer any question
- to ask the researcher to leave at any time
- to ask that the cassette recorder be turned off
- to examine any notes taken
- to read and amend any subsequent transcription
- to terminate the meeting at any time
- to be informed of the results (on completion of the research)

More information on the study can be obtained from the study supervisors

- Dr Cheryl Benn or Lesley Batten both at the School of Health Sciences, Massey University, Palmerston North. Tel (06) 356 9099.

If you have any queries or concerns about your rights as a participant in this study you may wish to contact Health and Disability Services Consumer Advocate, (Name Given), telephone (Code) 753 3861

No material which could possibly identify you, or people or place mentioned by you in the interview will be used in any reports on this study. The transcriber of the audio-tapes will sign a separate

confidentiality contract before commencing her work. Every effort will be made by the researcher to maintain your anonymity throughout the research project. Each participant will be referred to only by a pseudonym (which may be selected by you) or by a number.

It is hoped that the results of this study will be published in a professional midwifery journal and a woman's magazine.

This study has received approval from the (Named) Ethics Committee and Massey University Human Ethics Committee. Please feel free to contact the researcher if you have any questions about the study.

Thank you for your interest in this project and for taking the time to read this information.

APPENDIX D

INFORMATION SHEET

(MIDWIFE)

MASSEY
UNIVERSITY

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5668

COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

INFORMATION SHEET (MIDWIVES)

Title: What happens between the independent midwife and the woman at the first ante natal visit?

Researcher: Mary Sylvester, Massey University Student, Struan House, 95 Gover Street, (Named City). (Code) 758 3401

You are invited to take part in a research study to examine what happens at the first ante natal visit between the midwife and the women. This research is being completed as part of the requirements of a Master of Arts degree.

At the independent midwives meeting I will inform the midwives of the study and invite them to participate. Women will initially be approached by their independent midwife, at the first time of the first contact. I would like to talk to about 10-14 participants (midwives and women) and be present during the first ante natal visit. If you agree to participate you will be asked to sign a consent form. The interviews will be held either at your home or at a place nominated by you. After observing the first ante natal visit I will interview you within two weeks.

Thereafter, if necessary and further information is needed, one further interview will be held. The ante natal visit and the interviews will be audio-taped with your permission, to allow transcription of the data. Each interview will last between 1 - 1 ½ hours. You may request that

the audio-tapes be returned to you, otherwise the tapes will be stored in a secure place for five years then destroyed.

Your participation is entirely voluntary (your choice). You do not have to take part in this study. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your future practice

You have the right at any time during your participation

- to ask any question about the research
- to refuse to answer any question
- to ask the researcher to leave at any time
- to ask that the cassette recorder be turned off
- to examine any notes taken
- to read and amend any subsequent transcription
- to terminate the meeting at any time
- to be informed of the results (on completion of the research)

More information on the study can be obtained from

- Dr Cheryl Benn or Lesley Batten both at the School of Health Sciences, Massey University, Palmerston North. Tel (06) 356 9099.

If you have any queries or concerns about your rights as a participant in this study you may wish to contact Health and Disability Services Consumer Advocate, (Named), telephone (Code) 753 3861

No material which could possibly identify you, or people or places mentioned by you in the interview will be used in any reports on this study. The transcriber of the audio-tapes will sign a separate confidentiality contract before commencing her work. I will make every

effort to maintain your anonymity throughout the research project. Each participant will be referred to only by a pseudonym (which may be selected by you) or by a number.

It is hoped that the results of this study will be published in a professional midwifery journal and a woman's magazine.

This study has received ethical approval from the (Named) Ethics Committee and Massey University Ethics Committee. Please feel free to contact the researcher if you have any questions about the study.

Thank you for your interest in this project and for taking the time to read this information.

APPENDIX E

CONSENT FORM

(WOMEN)

MASSEY
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COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

CONSENT FORM (WOMEN)

TITLE

What happens between the independent midwife and the woman at the first ante natal visit

RESEARCHER

Mary Sylvester

I have read and understood the information sheet for volunteers to take part in this study. I have had the opportunity to discuss this study with Mary Sylvester and I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care. I understand that my participation in this study will be anonymous and that no material which could identify me will be used in any reports of this study. I have had time to consider whether to take part and I know who to contact if I have any questions about the study

I consent to my interviews being audio-taped. YES/NO

I wish to receive a summary of the results YES/NO

I ..... hereby consent to take part in this study.

If you have any ethical concerns about the study, you may contact (Named) Ethics Committee on (Code) 758 6648

A copy of the consent form will be retained by the participant.

Signature ----------

Date ----------

Full Name of Researcher ----------

Contact phone Number of Researcher (Code) 758 3401

This project has been approved by the (Named) Ethics Committee. This means the Ethics Committee may check that this study is running smoothly, and has followed appropriate ethical procedures. Complete confidentiality is assured.

APPENDIX F

CONSENT FORM

(MIDWIFE)

MASSEY
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COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

CONSENT FORM (MIDWIFE)

TITLE:

What happens between the independent midwife and the woman at the first ante natal visit

RESEARCHER

Mary Sylvester

I have read and understood the information sheet. I have had the opportunity to discuss this study with Mary Sylvester and I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future practice. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports of this study. I have had time to consider whether to take part and I know who to contact if I have any questions about the study

I consent to my interviews being audio-taped. YES/NO
I wish to receive a summary of the results YES/NO

I ..... hereby consent to take part in this study.

If you have any ethical concerns about the study, you may contact (Named(Ethics Committee on (Code) 758 6648

A copy of the consent form will be retained by the participant.

Signature ----------

Date ----------

Full Name of Researcher ----------

Contact phone Number of Researcher (06) 758 3401

This project has been approved by the (Named) Ethics Committee. This means the Ethics Committee may check that this study is running smoothly, and has followed appropriate ethical procedures. Complete confidentiality is assured.

APPENDIX G

INFORMATION TOPICS COVERED AT FIRST

ANTENATAL VISIT

INFORMATION TOPICS COVERED AT FIRST ANTENATAL VISIT

1. Information about the first visit.
2. Information about the midwife and her experience
3. Choosing an obstetrician and how to refer
4. Alcohol
5. Smoking
6. Information on effects of smoking and the dying of the midwife's own mother
7. Healthy eating and diet.
8. Listeria and where it is found.
9. Fibre and constipation
10. Breast feeding.
11. Cot Death
12. La Leche League
13. Scans
14. Antenatal classes and the providers
15. Information on the midwives groups and how they work
16. Home birth
17. Options
18. Folic Acid
19. Morning Sickness and Nausea
20. Changes to the body during pregnancy
21. Lead Maternity Carer and what it means
22. Scope of the midwife unable to do "medical stuff"
23. Differences between midwives, GPs and obstetricians
24. The meeting of other midwives and expectant mothers
25. In-depth discussion on how to contact the midwife
26. Resolution Committee

27. Information on midwife having time off and who covers
28. Information on the use of woman's own record card
29. Obtaining a GP in town
30. Complicated information given on LMP and how to calculate EDD
31. Explanation given on the definitions of the abbreviations found in the antenatal records
32. Explanation given on the blood tests being done
33. Information on weighing in pregnancy and why it is no longer done by the midwife
34. Information on "Toxemia"
35. In-depth discussion on what a blood pressure is and what it means
36. Clamidia
37. Information on early discharge
38. Alternative therapy
39. Thrush
40. Haemarroids
41. Dental care
42. Syphilis
43. Cervical smear after baby is born
44. Contacting the midwife first before contacting a doctor
45. Detailed information on urine testing
46. Function of the kidney
47. Obtaining secondhand clothes
48. Vitamin K
49. Immunisation
50. Effect of progesterone on ligaments, blood vessels and blood volume
51. Information on labour
52. Support stockings
53. Foot exercises
54. Back-care
55. Role of midwife in labour

56.Post natal visits

57.Payment system of midwives

58.Changing caregiver

59.Car seat

60.Becoming a father

APPENDIX H

ANTENATAL NOTES

BIRTH BOOKING FORM

LMC _____
G.P. _____
NHI. _____

:pected ALOS 48 Hrs Postnatal

)ther's Full Name: _____ DOB: __/__/__ AGE ____
:evious names mother known by: _____ Race: _____
ldress: _____ Phone: (H)_____ Marital Status: _____
_____ (W)_____ LMP__/__/__ EDD__/__/__
)K: _____ Relationship: _____ Sure / Unsure LMP
)K Contact Details: _____ Adjusted Date _____

EDICAL | HISTORY | SURGICAL

Midwifery Care Provider
Name: _____
CHE / Ind M (Circle)

History Taken By: _____
_____
Designation _____

.MILY | SOCIAL

Cycle: Reg/ Irreg:
Oral Contraceptives:
Details .....
Smoking: Y N
Number per day:

LLERGY STICKER | MEDICATIONS

BSTETRIC HISTORY: GRAVIDA: PARITY:

ice Of livery	Date	PREGNANCY Duration weeks	PREGNANCY Complications	LABOUR OR MISCARRIAGE Duration	LABOUR OR MISCARRIAGE Complications	Puerperium	INFANT Sex	INFANT Alive NND SB	INFANT Birth Weight (grams)	INFANT Feeding (months)

)bstectric Risk Factors | Special Instructions:

MC to forward to ward clerk, maternity unit, [redacted] by 20th week of pregnancy

BOOKING INVESTIGATIONS

	Date	Date
Hb: MCHC:		
V.D.R.L.		
Rubella Screening		
H.B.V. Surface Antibody		
Blood Group ABO / Rhesus		
Antibodies		

CONSENT FORMS

Attach Patient Label Here

Consent for Ecbolic Medication.

I _____ consent to receiving an Ecbolic and have had the side effects of this medication explained.

Date: _____ Signed _____ Witness _____

Consent for Vitamin K.

I _____ consent to Vitamin K being given to my baby (by injection/orally delete one) and have had the effects of this medication explained.

Date: _____ Signed _____ Witness _____

Consent for Rubella Vaccine.

I _____ consent to receiving Rubella Vaccine. It has been explained to me that if I conceive within the next three months the foetus could be at risk. Family Planning advice has been offered to me.

Date: _____ Signed _____ Witness _____

Rubella immunistaion required YES/NO Batch No: .... Date: ..... Signed:.....

Other Relevant Information

Mother issued a copy of the birth pathway on booking

Signed: .....

Date: .....

(Office Use Only)
All details completed and booking accepted

Signed: .....
Designation: .....
Name Printed: .....

PRE-NATAL

FIRST VISIT

General condition–

Teeth: _____

Heart: _____

Lungs: _____

Breasts: _____

P.V. Discharge: _____

Varicose Veins: _____

Height

Weight

non pregnant

NOTES:

PELVIC EXAMINATIONS

First Visit-- [ ] weeks

Reassessment– [ ] weeks

Date	Urine		Wt. Kg.	Oed.	B.P.	Maturity**		Presn.	Posn.	Descent 54321	F.H.	Remarks, Discharge, Prescriptions, etc.	Next Date	Name
	Prot.	Sug.				Calc.	Clin.							

DATE	REPORT	SIGNATURE

APPENDIX I

DEFINITION OF A MIDWIFE

DEFINING A MIDWIFE

The Nurses Amendment Act (1990) allowed midwives to practice midwifery as defined by the WHO [, 1966 #116] as:

> A person, who having been regularly admitted to a midwifery education programme duly recognised in the jurisdiction in which it is located, has successfully completed the prescribed course of study in midwifery and has acquired the requisite qualifications to be registered and or legally licensed to practice midwifery.
>
> The sphere of practice: She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
>
> She has an important task in counseling and education - not only for patients, but also within the family and community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care.

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