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The specificity of the individual professional practice of midwives with regard to home births. Analysis of the 'relationship field'

Abstract

Introduction. By virtue of the Act of 5 July 1996 on the occupation of nurses and midwives, a midwife in Poland has full professional autonomy. The Act does not forbid conduct of individual practice outside of a hospital.

Aim. The purpose of the article is to present practical execution of individual practice of assisting during home birth with regard to relations between the midwife and the woman giving birth.

Materials and methods. The issues presented in the article are a part of broader research concerning home births in Poland. The research was commenced in 2014 and finalized in 2018. The analysis concerned statements of women who decided not to give birth in a hospital. I obtained the empirical material through in-depth interviews and I referred to data existing in the form of e.g. blog entries. Finally, I collected 40 descriptions of home births. They underwent a qualitative analysis with the use of the grounded theory methodology and the social world theory.

Results. The outcome of the research is a multifaceted "sociological portrait" of the world of women, which implement an alternative to the hospital birth scenario. In the article, I limit myself to the presentation of mechanisms of transformation of midwife-birthing woman relations from professionally neutral to emotionally involved: mutual appreciation, balancing of positions, comprehensive qualification, systematic maintenance of relations, and feminization of birth. I also presented the principles of cooperation with the birthing woman during home birth: constant and imperceptible presence, following a woman, patient accompaniment, support, animation of bonds, and respect for the ceremony. The whole discussion depicts the special character of the individual practice of midwives with regard to the field of relations.

Conclusion. Reference to childbirth experiences allowed for identifying potential expectations of women planning to have children towards the midwife's profession, as well as the possible paths of professional development of representatives of this profession, especially in the face of the growing awareness and autonomy of people using health care services. These issues may also be treated as an element of a broader discussion on the shape of an optimum pre- and post-natal care.

Keywords: obstetrics, private midwife, perinatal care, home delivery, relationships.

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INTRODUCTION

According to the Act of 5 July 1996 on the occupation of nurses and midwives, a midwife in Poland has all required competencies to exercise independent care over a physiologically pregnant woman, deliver the baby naturally, care over the mother and the child in the post-natal period, and can also independently perform specific preventive, diagnostic, medicinal, and rehabilitation activities [1]. Due to the home birth issues adopted in the article, it should be emphasized that the Act does not forbid midwives to perform the aforementioned tasks outside of a hospital. Furthermore, the Regulation of the Minister of Health of 20 September 2012 on the so-called pre- and post-natal standards contains a provision confirming the right of women to choose the place of childbirth, including their home [2]. In practice, a very small percentage of women in Poland (less than 1%) chooses such a solution [3], and home birth is usually perceived as a relic of the past, a sign of irresponsibility or an incomprehensible choice of eccentrics [4]. Meanwhile, individual practice of midwives, including delivery of children at home, was acknowledged by the World Health Organization (WHO) as an important element of pre- and post-natal care model recommended by this institution. The role of midwives was appreciated especially in the context of recommendations on the need to replace individual medical (hospital) supervision with a broader system embedded in the local community. It means that all pregnant women, not only those belonging to the risk group, should be provided with "close-to-client" care, decentralized, respecting specific social and cultural conditions, based on the vision of childbirth as the central point of life of the family and based on services of midwives (possibly doctors, nurses) provided in hospital obstetric wards and midwife-led facilities – a combination of social, non-medicalized but professional care. This system, which the WHO refers to as "first-level care", should be compatible with the higher-order structure ("back-up care") based mainly on activities of gynecologists-obstetricians and pediatricians, responding to problems that could not have been resolved

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at the first level [5]. The WHO does not exclude home births from the recommended system, and even indicates the need to regulate them legally, so that they constituted an integral element of care and an option of women's conscious choice (rather than a symptom of deficit in medical and hospital care) [6]. In the discussion on the organization of the system of care over a pregnant/birthing woman, an important thread that is stressed by the WHO covers her relations with health professionals. The announcement of 2015 paid attention, among others, to the lack of respect for women's intimacy, violation of their right to privacy and full information, verbal violence, and communication barriers in medical institutions as violation of basic human rights. The document moreover emphasizes that no uniform methodology for examination of "obstetric transgressions" have been developed, and thus the scale of the problem and its effect on welfare of women and children is not adequately recognized. At the same time, it recommends conduct of systematic research concerning childbirth experiences in order to make their adequate diagnosis and to develop tools for counteracting improper treatment of women [7]. In the light of the above recommendations, the analysis of the individual obstetric practice presented in the article with regard to relations between the midwife and the woman giving birth at home can be treated as a significant thread in the general debate on the optimal shape of pre- and post-natal care.

AIM

The purpose of the article is to present practical execution of individual practice of assisting during home birth with regard to relations between the midwife and the woman giving birth.

MATERIAL AND METHODS

The discussed issues are a part of a broader research project concerning home births in Poland. The research was commenced in 2014 and finalized in May 2018. The analyzed material consisted of data obtained through in-depth interviews [8] with women who consciously decided not to give birth in a hospital and statements of such persons posted e.g. on the Internet. Finally, I collected 40 descriptions of home births and subjected them to a qualitative analysis on the basis of the grounded theory methodology (GTM), which has presently become one of the most frequently used orientations in qualitative research, especially in the area of health and disease issues [9]. Generally speaking, GTM is "(…) a method of conducting qualitative research, in which focus is put on creation of frameworks or theories as a result of building inductive analysis on the basis of data. Thus, analytical categories are directly «grounded» in data. In this method, analysis is more important than description, new categories are more important than preconceptions and existing theories, and systematic collection of subsequent data – than larger initial samples. This method is different from others because, when collecting data, the researcher commits to their analysis – this data analysis is used to supplement and shape the process of collection of subsequent data. Thus, in research based on the grounded theory methodology, this clear distinction between the data collection process and the analysis stage, which exists in traditional research, was intentionally blurred" [10]. An important element supplementing my research was also "the social world theory" methodology, popularized, inter alia. by A.L. Strauss [11], from whom I took notions normally used to describe various "social worlds" (e.g. the world of sport, dancers, politicians, medicine, etc.): primary activity, boundaries, actors, arena, trajectory of "becoming", legitimation, theorization, technologies. Such a methodological approach has become the basis for constructing a sociological portrait of the environment of women giving birth at home, or an "integrated central theoretical framework" [12] illustrating the rich spectrum of strategies of pursuing a childbirth scenario alternative to the hospital one. In the article, I am limiting myself to presentation of results concerning the relations and terms of cooperation between a midwife and a woman giving birth at home .

RESULTS

I describe the special character of the individual practice of midwives by referring to a set of categories identified in the course of the analysis, by means of which results of qualitative research are usually presented [9]. These categories focus on two basic issues: relations between a midwife and a woman giving birth as well as principles of cooperation with the future mother during childbirth (of course, I am aware that there are also other important elements of the work of independent midwives –inter alia the issue of professional liability, medical standards of conduct, ethics or legal, organizational and technical issues).

At the beginning, it should be emphasized that what mostly shapes the relationship between a midwife and a woman giving birth at home are specific linkages of two "worlds" – medicine, being a symbol of the system and official procedures, and home, embodying intimacy, privacy and close relations. In this system, the midwife is both the guardian of formal requirements and of the woman's comfort, an emanation of institutional order, but also a person emotionally significant. In hospital conditions, the relationship with the birthing woman does not usually go beyond necessary medical activities and there is no place here for development of a bond satisfactory for both parties and, as a consequence, the woman is confronted with the "cold routine" of detached health professionals. This problem is perceived in the narrations I have analyzed as a serious deficit of provided care. Therefore, women justified their decision to give birth at home, inter alia, by the possibility of obtaining multi-faceted support from a midwife, not limited to "technical service". Moreover, on the basis of their statements, it can be stated that birth is seen as a type of celebration for which selected people are invited. Therefore, the midwife is included in this event under the condition of establishing a special relation with the woman – she must become not only the person who provides the service of child delivery, but also the person emotionally significant. To sum up, in the event of home birth, the midwife - in spite of the fact that she personifies "the medical world" – is not treated by women giving birth at home as a necessary intruder insistently controlling the whole event. This close bond between them is developed in the process that I call "privatization of relations", consisting in its transformation from professionally neutral to emotionally involved. Privatization takes place through the implementation of specific strategies that create the optimal interactive climate for undisturbed communication, agreement and trust, which are necessary in a safe home birth.

The first strategy of privatization of relations which I am focusing on is "mutual appreciation", consisting, on the one hand, in the birthing woman appreciating the midwife as an independent professional and, on the other hand, the midwife respecting the woman's subjectivity and recognizing her as an "expert in childbirth". The midwife's appreciation may be seen as a reaction to the double depreciation she experiences in hospital conditions: due to performing a subordinate role to a doctor and reduced possibility of initiating and maintaining a satisfactory relation with the birthing woman. In the analyzed comments, women thus appreciated the midwife's profession firstly by questioning the role/competences/knowledge of a doctor with regard to non-pathological childbirth. Such a position results from their belief that, since birth is a natural process, medical intervention should be conditional – in the event of a threat to health or life. Underplaying of the role of a doctor means a deep change in the power structure in the field of relations, since his institutional superiority is cancelled, and key importance is gained by the midwife's position – the studied women assigned her the status of a medical authority with regard to physiological child delivery. Secondly, the midwife's appreciation consists in establishing proper conditions for performing obstetric care in a significantly broader meaning than only performing medical supervision over correct course of childbirth (how is this care understood precisely is discussed further in the article). As it has been already indicated, appreciation also applies to the future mother and consists in recognizing her not only as the main actress in childbirth, but also as its director. This strategy consists in emphasizing her natural competences to "manage" the childbirth are in the midwife creating conditions for practical exercise of her autonomy during childbirth. Both parties of the interaction thus make the assumption that the proper course of childbirth depends on active attitude of the woman, familiarity with her own body and acknowledgment that childbirth is a manifestation of her "true nature". Another significant change in the system of interactions takes place here – the external expert (medical personnel) is replaced by an internal expert, and the authority is shifted towards the birthing woman – her body, instinct and intuition. Childbirth is thus, in the case of women giving birth at home, a space of adaptation of what the system offers (the hospital and medical childbirth model) to the woman's own preferences. In this view, the role of a midwife is not to control, but to assist the woman and interfere only when necessary.

"Mutual appreciation" is only the beginning of the transformation of relations between the midwife and the birthing woman from purely professional to emotionally involved. Another strategy of privatization is "balancing of positions" through two-way qualification of when both the midwife and the future mother have impact on the choice of the right person. In the case of home birth, we are dealing with a careful process of "recruitment", a conscious elimination of people who do not meet the right criteria established by the midwife/the birthing woman. At the same time, we have a reversal of the order – in a hospital, the woman usually does not know the midwife accompanying her during childbirth, and even if the birthing woman is satisfied with her care then – because of the shift-based character of work –

there are no opportunities for building a satisfactory, sustainable relation. At home, the woman, as the main actress/director of childbirth, makes an autonomous decomposition of the system of roles and relations between participants of childbirth events, thus avoiding the randomness of a hospital. Moreover, by making a conscious choice, she frees herself from the pattern of hospital subordination. However, it should be remembered that the choice of a midwife does not consist in "purchasing a service provider". The midwife also qualifies the birthing woman, and this takes place practically until the childbirth during systematic meetings with the future mother. What is interesting, the assessment of her "capacity" to birth a child outside a hospital is based not only on health parameters, but also on her psycho-social predispositions. The family situation of the future mother is also taken into account – e.g. the relation of the partner towards home birth. The midwife's activity in this respect causes a real balancing of positions to form between the midwife and the birthing woman, and the relation between them is built mutually (woman's trust – midwife's trust).

Another important condition for privatization of relations, which can be treated as a different aspect of the previous thread, is performance of a mutual "comprehensive qualification". In their selection, the birthing woman follows not only an assessment of the midwife's professionalism, but also her personality – what kind of a person she is as how the future mother is feeling in her presence. In this sense, we can refer to a total nature of the midwife's profession, not reduced to technical service provided to the birthing woman. As it has already been mentioned, the midwife also follows extensive criteria of qualification for home birth – apart from the obvious health conditions, she also takes into account character traits of the future mother. A comprehensive approach, implemented by mutual matching of two personalities, is in fact a departure from the "service provider-receiver" relation for the benefit of "human-human" system. It creates real chances for initiating a more "humanistic" relation, streamlining communication or creating a sense of safety.

Another element of privatization of interactions between the midwife and the birthing woman is "systematic maintenance of relations". As it has already been mentioned, in the situation of a hospital birth, the pregnant woman often meets the midwife for the first time, and the shift rotation distances her even further from the personnel. On the other hand, home birth is a result of many months of observations and establishment of relations. The midwife remains with the future mother in constant contact (this also applies to the post-natal period), thus removing the sense of detachment that the birthing woman can feel in contact with a medical professional in a hospital. This relation is even more deepened/strengthened by involving the same midwife in further childbirths, and thus she becomes someone akin to a family friend.

There is one more, quite non-obvious but significant aspect, facilitating creation of satisfactory relations, which was indicated by authors of statements I have analyzed – it was the fact that midwives are women, and thus they have natural legitimacy to participate in such an event as birth of a child. In this sense, we can refer to "feminization of childbirth", consisting in acknowledgment of femininity as a kind of professional competence additionally sanctioned by a multi-century tradition of care over a pregnant/birthing woman. This is particularly evident in descriptions of crisis moments during childbirth, when this femininity was the source of strength and motivation for the birthing women to face their difficulties. A different meaning of "feminization of childbirth" consists in experiencing the birth as a time when the birthing woman gains a new identity,

reaches the essence of femininity, finds herself in a number of generations of women, whose presence – as they claim – could be felt during the birth (in this context, they used such terms as a "proto-mother", an "old wise woman" who they "reached" at some point of the childbirth and who became someone akin to a guide for them). Therefore, what enables home birth is an eruption of natural feminine power, which is often stifled and restrained in hospital conditions. Building relations with the midwife by appealing to women's understanding makes the area of childbirth definitely become the domain of women.

Now, I want to focus on several principles of the midwife's work with the birthing woman during home birth that I have identified on the basis of the analyzed empirical material. Those include, among others, the principle of "constant presence" and "imperceptible presence". Contrary to giving birth at a hospital maternity ward, a woman giving birth at home has the constant and full attention for a midwife. The midwife's attention is absolutely focused on the mother – in home conditions, she is not distracted by the hospital rush, excess of bureaucratic obligations or the need to take care of many women at the same time. As a representative of the "medical world", she also needs to fulfill all formal requirements while simultaneously respecting birth as a type of family celebration. From this point of view, one of her vital competences is the ability to efficiently albeit unimposingly include strictly obstetric activities in the private, intimate space of childbirth. The outcome of balancing both aspects is, on the one hand, not burdening the pregnant woman with necessary procedures while at the same time providing her with medical security. That is where the second of the aforementioned principles stems from – the "imperceptible presence" of the midwife, who is able to tactfully ensure the comfort of the future mother as well as perform the necessary obstetric activities.

Another principle present in the examined narrations is the principle of "following a woman". In practice, it means adopting an open and flexible attitude towards her, as well as a careful but unimposing monitoring of the woman during childbirth and, on this basis, ongoing modification/adaptation of activities undertaken towards her. The main focus and the most important reference system thus consists of needs of the future mother. This means deviation from hospital patterns and imposing the role of a passive patient onto the woman, which limits articulation of her own preferences. The principle of "following a woman" is implemented by emphatic intervention and withdrawal of the midwife – sensing when the birthing woman's activity should be allowed and when she should be given space, so that she could guide the birth herself, and when to step in with mild discipline, mobilization or support. An important aspect of the concerned principle is respecting the birthing woman's freedom with respect to the choice of position and behavior during childbirth – as "an expert in childbirth", she has the inalienable right to such freedom. At this point, we can also notice the difference from giving birth in a hospital, where the woman has to submit to the institution's rigor in this aspect.

"Patient accompanying" is the next characteristic pattern of the midwife's work during home birth, consisting in respecting its individual pace – it is assumed in this case that the birth should not be routinely accelerated, otherwise its natural course is violated at the cost of the mother and child's health. In this case, the midwife abandons the hospital rush and adopts an "anticipative" attitude. Respect for the physiological pace of birth is directly connected with respect for its natural course, which I call "protection of naturalness". It consists in avoiding routine medical interventions (e.g. administering oxytocin, performing episiotomy, puncturing the amniotic cavity), but also the use of a whole range of natural methods supporting the birthing woman (e.g. baths, compresses, massage, breathing exercises, proposing specified positions, using a ball, sako sack, visualization, having conversations). Knowledge of many techniques helping the woman face the struggle of childbirth indicates another element of the midwife's work that is usually not sufficiently performed in the hospital rush – it is the "support" principle. Support in this case is understood broadly – it is not only about the medical "safety umbrella", but also careful and constant monitoring and responding to the needs of the birthing woman. The midwife in this situation, like a lighthouse guiding in the right direction – does not impose her assistance but offers it, does not control but co-participates, does not order but suggests. In this aspect we can fully see the harmonious merger of knowledge/skills and psycho-social competences, typical of the midwife's profession. It is worth emphasizing that support provided by the midwife is not limited only to the birthing woman (and her child) but also includes her partner and sometimes other relatives (e.g. becoming the "informer-translator" for the woman's parents or parents-in-law, who have difficulties with accepting the decision to give birth at home).

An interesting point in the examined narrations was the activity of midwives regarding "animation of bonds" between the mother and the newborn child. Before I discuss methods of stimulating the bond between them, I want to note that the puerperium period in the case of home birth is subject to the special appreciation – it is not only the time of rest or medical supply of the woman, but also the next stage of birth, equally important as the previous ones (pregnancy, childbirth). It is a time to welcome a new person to the world, say hello to the family, gradually entering the role of a mother. In this situation, it is typical to strive to slow down the passage of time to allow the woman and the child uninterrupted contact and to "kick-start" hormones, instincts facilitating establishment of relations. This is achieved by immediately breastfeeding the child, applying the "skin to skin" method, not rushing nursing activities performed on the newborn or delaying the cutting of the umbilical cord. The "slowdown" understood in this way is a type of buffer against a sudden change typical of a hospital, where the personnel expects the woman to enter the role of a mother perfectly straightaway. In this sense, the bond-creating aspect of the puerperium is seriously neglected, what may cause disturbed relation with the child, problems with breastfeeding, a sense of solitude or post-partum depression. In the case of home birth, provision of an accordingly long time helps the mother get into her role, achieve balance and accept her new responsibilities.

The last, quite particular, pattern of the work of a midwife assisting during home birth I am focusing on is "respecting the ceremony". In the examined narrations, childbirth is perceived as a type of a family festivity celebrated among family and friends. Future parents sanctify this event by praying, meditating, listening to music, lighting candles, lighting a fireplace or by doing a photoshoot. Therefore, a significant competence of midwives is the ability to skillfully integrate into this festive space. On the other hand, childbirth is interpreted as a natural element of family life – by resigning from giving

birth in a hospital, authors of the analyzed descriptions incorporate childbirth into the daily life, thus contradicting its medical interpretation. Thus, childbirth is incorporated, despite its extraordinariness, into the rhythm of life of household members. This daily life is entered by the midwife, who – in a sense – is also becoming a household member: she has meals together with the family, helps with cleaning, takes care of the children for a while when necessary. Thus, she removes from view of being attributed to medical world, from which women giving birth at home distance themselves.

DISCUSSION

The above deliberations show the performance of individual practice of midwives with regard to the area relations with women giving birth at home. The main focus ordering the whole discussion is the perspective of laypeople – in my analysis, I referred to experiences of women giving birth at home, which made it possible, on the one hand, to identify expectations of women planning to have children towards the midwife's profession and, on the other hand, to present potential paths of professional development of representatives of this profession. Taking on this subject matter also means taking a stand in the discussion mentioned in the introduction to this article, concerning transgressions in the way women are treated during childbirth and generally concerning pre- and post-natal care in developed countries which, as believed by researchers of these problems, is in a serious crisis [13]. One of the strategies of dealing with this crisis would be appreciating the care of midwives, also those conducting individual practice in the form of home births [14]. These deliberations are also important in the context of the debate on the prestige of the midwife's profession, which is usually associated with mid-level/auxiliary medical personnel. The analysis of assistance during home birth shows this profession as a special merger of tradition and modernity, as well as a type of creative reconstruction of the traditional role of an accoucheuse, whose role was not limited to performing technical activities during childbirth but also included support and consulting in the woman and child's health [15]. In this particular situation, it can be seen how professionalism based on medical knowledge is combined in practice with empathy, intuition and communication skills.

CONCLUSIONS

The outcome of the research is identification of a set of mechanisms of transformation of relations between the midwife and the birthing woman from professionally neutral to emotionally involved. These mechanisms are: mutual appreciation, balancing of positions, comprehensive qualification, systematic maintenance of relations, and feminization of birth. Privatization of bonds understood in this way results from the future mothers' need for extensive assistance of a midwife, including not only medical activities but also broadly understood psychosocial support. I also presented the principles of cooperation with the birthing woman during home birth: constant and imperceptible presence, following a woman, patient accompaniment, support, animation of bonds, and respect for the ceremony. The whole discussion depicts the special character of the individual practice of midwives with regard to the field of relations.

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