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Danielle Matthys
Western Michigan University, dg616@hotmail.com

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The Carl and Winifred Lee Honors College

THE CARL AND WINIFRED LEE HONORS COLLEGE

CERTIFICATE OF ORAL EXAMINATION

Danielle Matthys, having been admitted to the Carl and Winifred Lee Honors College in Fall 2002 successfully presented the Lee Honors College Thesis on April 18, 2006.

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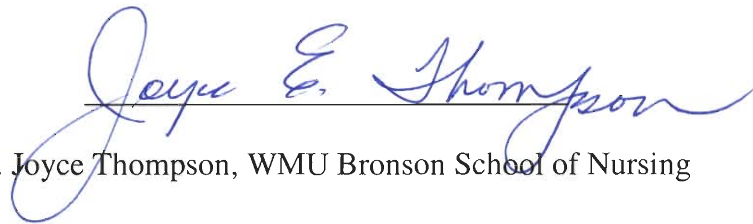
"Exploring the Relationship Between U.K. Midwives and First-Time Mothers Receiving One-To-One vs. Standard Midwifery Care During the Postnatal Period"



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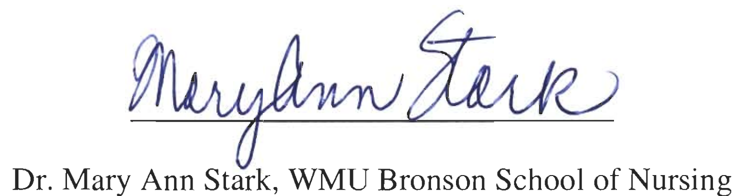

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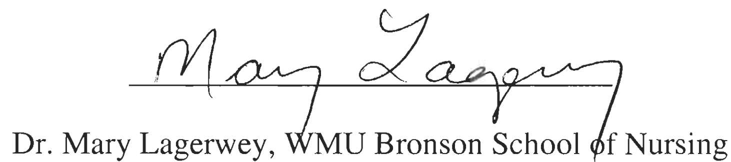

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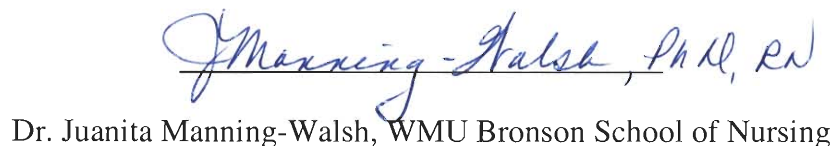

Dr. Juanita Manning-Walsh, WMU Bronson School of Nursing

1903 W. Michigan Ave., Kalamazoo, MI 49008-5244
PHONE: (269) 387-3230 FAX: (269) 387-3903

Exploring the relationship between U.K. midwives and first time mothers receiving One-to-One vs. standard midwifery care during the postnatal period.

Danielle C. Matthys

Western Michigan University

Honors thesis project

Introduction

Initially when researching how to best use the opportunity to travel to the United Kingdom (U.K.) and integrate the exploration of midwifery practice into an honors thesis research project, many ideas emerged. One stood out in particular. As an American nursing student, only one form of U.S. midwifery practice had been observed; namely, where the expectant mother receives care from a multitude of practitioners. This care was observed both in a large tertiary center and smaller community hospitals. Unknown prior to researching the history of midwifery, however, a model of midwifery care called One-to-One began in 1993 in England (Page, 2003). The student researcher became intrigued with this model as she explored the literature. In this model, the expectant mother works with only one or two midwives during the course of her pregnancy and birth. Continuity of carer is stressed, providing for an ongoing and personal relationship between each woman and her midwife. Many facets of midwifery practice could be studied, but the strength of the relationship that occurs with the One-to-One model was particularly fascinating.

Expert midwives have described the relationship in midwifery as including the woman, the midwife, the alliance between them, and the environment of care (Kennedy, Rosseau, & Low, 2003). The practice of midwifery itself represents a coming together of midwife and woman, the intermittent contact between these two people and the differences in intensity of the relationship at different periods of the relationship (Fleming, 1998). As in any relationship, be it friendly, romantic, or professional, there is a give and take quality between the two parties that is ever-changing and unique. Thus, the purpose of this qualitative study was to describe the relationship between U.K.

midwives and first time mothers receiving One-to-One vs. standard midwifery care with a variety of practitioners during the postnatal period in England.

Review of Literature

Computerized searches of MEDLINE and CINAHL databases were conducted to gather literature from 1991-2005. Search terms were one-to-one, midwifery, relationships, and postnatal and included only English-language articles. Additional sources of information were identified from the references of selected articles found to be directly related to the relationships between midwives and women.

Thirty resources were relevant after the search, and twenty-one were utilized. Most journal articles were based on personal interviews from midwives and/or mothers. Some described qualitative studies, and twelve used survey and interview techniques with subjects. Taken as a whole, these studies addressed all periods of pregnancy and birth. First-time mothers as well as experienced mothers were included in the studies, as were midwives from all types and settings of care (i.e. One-to-One, standard, hospital, birth center, home). One major cohort study was incorporated as well as various metasynthesis studies. Limitations in these studies were small sample sizes (sometimes as few as five midwives), biases from self-reporting, lack of ethnic diversity among the midwives and mothers, and lack of randomization leading to limited generalization.

One-to-One Model of Midwifery

The One-to-One Model of Midwifery was established in the Hammersmith Hospitals National Health Service (NHS) Trust at both Hammersmith and Queen Charlotte's Hospitals in West London, England in November 1993 to put the principles of *Changing Childbirth* into practice (Page, 2003). *Changing Childbirth* was a report

generated by the nine-member Expert Maternity Group outlining the maternity services deemed important by the unsatisfied British public. These included: 1) having women involved in making informed decisions, 2) accessible and attractive maternity services, and 3) public involvement in the monitoring and planning of the services (Page, 2003). *Changing Childbirth* includes 'Indicators for Success' for continuity and midwifery led care (CMP, Retrieved 1/3/2005 from http://www.wolfson.tvu.ac.uk/cmp/oneto onesummary.html). For example, a continuity indicator was that 75% of women in the United Kingdom should be cared for during their birth by a known midwife (Walsh, 1999). If all women in the U.K. were to receive One-to-One midwifery care, this particular success indicator would be exceeded.

In the One-to-One model of care, each midwife carries a caseload of 40 women. Each midwife has a partner who also gets to know the women in the other's caseload in case the designated midwife should be unavailable. The partnerships are within a larger group of six to eight midwives who participate in peer review, mutual support, and backup. One-to-One midwives serve both low- and high-risk women in hospital and community settings. If the pregnancy is high-risk, an obstetrician consults the care but the midwife provides the care (Page, 2003).

The key principles of choice, continuity and control are the focus of One-to-One midwifery. Continuity of carer provides the opportunities to develop a close and personal relationship between each woman and her midwife (Page, 2003). Some have observed that One-to-One is similar to community midwifery before birth in the United Kingdom became institutionalized. Much of the success of the One-to-One model lies in the

attention given to the importance of the relationship between the woman and her midwife (Page, 2003).

Standard Midwifery Model of Care in the U.K.

Maternity services for women in institutionalized standard NHS care are provided by a mixture of community midwives, family physicians, and hospital-based midwives or physicians in the antenatal period and usually by hospital-based midwives or physicians in the intrapartum period followed by midwives and family doctors in the postnatal period, which takes place primarily in the woman's own home (Page, 2003). A higher number of practitioners are seen in the traditional model of care during the course of pregnancy, with not as much opportunity to build a close relationship with one or two persons. In a second cohort study evaluating One-to-One midwifery, Beake, McCourt, & Page (2001) found that almost one half of women in standard care (42%) saw the relationship with their main carer as 'routine'.

Framework utilized

Relationship-centered care (RCC) was chosen as the conceptual framework for this study based on the review of thirty resources. RCC is healthcare in which relationships are valued and attended to and includes relationships between and among practitioners, patients, and the community (Malloch, Sluyter, & Moore (2000) & Tresolini & the Pew-Fetzer Task Force (1994), as cited by Manning-Walsh, Wagenfeld-Heintz, Asmus, Chambers, Reed, & Wylie, 2004). The RCC framework acknowledges the importance of interpersonal relationships for improving and maintaining health. The model consists of five ascending levels, each serving as a base for the next level: self, self-others, reciprocal learning, mutuality, and transformed relational capacity (Manning-

Walsh, Wagenfeld-Heintz, Asmus, Chambers, Reed, & Wylie, 2004). Each of these levels are viewed within three domains, which include patient-practitioner, practitioner-practitioner, and community-practitioner. The essence of the relationship between the midwife and a woman can be understood by all these elements, most specifically in the patient-practitioner domain. Reciprocal learning occurs through an equitable alternating exchange of teaching and learning with another person (Hagerty & Patusky (2003), as cited by Manning-Walsh, Wagenfeld-Heintz, Asmus, Chambers, Reed, & Wylie, 2004). In health-oriented care, such as childbearing care, the patient is the expert when it comes to her own health and behavior and the practitioner is the learner. Mutuality is accomplished in the relationship when healthy interdependent bonds of connectedness are formed. Through these bonds, the establishment of common goals and consensus leads to a desired reality. The final level, transformed relational capacity, arises when the practitioner continues or leaves a relationship, forever changed because of the relationship and capable of expanding and deepening relationships to an even greater extent in the future (Manning-Walsh, Wagenfeld-Heintz, Asmus, Chambers, Reed, & Wylie, 2004).

Three supporting studies that were unique to midwifery care contributed additional information related to and supported elements of RCC, highlighting the importance of the nature of the relationship between the midwife and the childbearing woman. The first of these models is the *Conceptual representation of the metasynthesis of midwifery care* (Kennedy, Rousseau, & Low, 2003), which demonstrates the midwife and woman as having a continual flow in their relationship, 'taking control and letting go' as both parties work toward shared goals. Secondly is *The Thematic Representation*

of Narrative Coding Scheme specific to the midwife in relationship with the woman (Kennedy, Shannon, Chuahorm, & Kravetz, 2004). In this model, the authors list what the relationship is founded on (mutuality), followed by how the relationship is enacted and supported. The final framework is *Women-with-midwives-with women: the conceptual model* (Fleming, 1998). Fleming's model includes the core category of reciprocity, with six major categories that intertwine between the midwife and woman, including attending, presencing, supplementing, complementing, reflection, and reflexivity.

An Overview of Relationship factors

A majority of the literature reviewed described women as having more powerful, intimate, and rewarding relationships with midwives when receiving continuity of care (Page, 2003; Singh, 2001; Tinkler & Quinney, 1998, Walsh, 1999). One example was a retrospective study conducted by Spurgeon, Hicks, & Barwell (2001). Two pilot midwifery-led groups of women reported via questionnaire at six weeks postpartum a greater sense of empowerment and a greater sense of involvement and partnership between the mother and midwife compared to the control group who received standard obstetrician-led care during all three stages of childbirth. Midwifery-led care was much preferred to obstetrician-led care but did not lead to any deficits in clinical outcomes.

Page (2003) states that an overwhelming amount of the evidence suggests the special relationship that may develop between women and their midwives is seen as important in itself and a source of satisfaction to midwives. Walsh (1999) found that mothers value the attributes of listening, respecting, supporting, being sensitive, honest, individualizing care and sharing information.

A variety of actions, emotions, and concepts fall under the umbrella concept of "relationship" in midwifery practice. Central to this is that the midwife "works with" rather than "doing to or for" the women and families she cares for (Page, 2003). The woman is the one in control of her body and makes all the important decisions, with the midwife being present to guide and offer assistance as needed. Stemming from the relationship can come respect, communication, a sense of security, reciprocity, friendship, intimacy, dependency, and grief. These were eight main themes found in several sources (Fleming, 1998; Kennedy, 2003; Page, 2003; Walsh, 1999) and served as a guide when observing and interviewing midwives from both models of care in the United Kingdom.

Relationship Themes Used in the Study

Respect is necessary in any relationship in order for both parties involved to feel valued, appreciated, and esteemed. Respecting and responding to the woman's desires indicates that the midwife regards the woman's goals even when they may differ from her personal values (Kennedy, Shannon, Chuahorm, & Kravetz, 2004). Through a three-round Delphi study of 52 expert midwives, Kennedy (2000) found that midwives respect the uniqueness of the woman and her family by being culturally aware, involving the family with the experience of birth, and being sincere when giving comments. The midwife strives to maintain a respectful environment and offers positive encouragement and validation of the woman's work and efforts, not empty praise.

Communication is a reciprocal process of sharing information and knowledge between two people and is complex and multifaceted. Communication is identified throughout the literature as being of paramount importance to the midwife/mother

relationship (Battersby, 2001). In a qualitative study involving midwives participating in in-depth interviews, McCrea & Crute (1991) discovered that midwives said it was easier to build a relationship with clients who were chatty, outgoing and willing to open up than those who did not listen or gave no feedback. The midwives also tended to withdraw from the relationship if there were no clear physical or emotional needs from the mother.

Stamp & Crowther (1994), in a survey of 235 postpartum women, found that there is the potential for the mother to experience more conflicting advice with traditional care because of various providers, which may in turn erode the mother's confidence. There is also an increased sense of formality within the realm of traditional obstetrical care, which may be illustrated by the practitioner not addressing the mother by her first name. Women reported feeling depersonalized and ignored when receiving traditional care (Walsh, 1999). Sometimes, hospital policies which were in conflict with what the midwives considered being good practice also led to distressed communication (i.e. honesty between midwives and clients) (McCrea & Crute, 1991).

Listening is fundamental to the midwife-mother relationship (Battersby, 2001). Many women endure postnatal problems because they think they are normal (Ockenden, 2000). McCrea & Crute (1991) state that time needs to be set aside from routine care for empathic listening This may be demonstrated by simply listening to a woman's thoughts, feelings, and concerns and offering emotional support. Empathic understanding of clients' concerns is considered a vital component for the relationship to move towards therapeutic ends (Mearns & Thorne (1988), as cited by McCrea & Crute, 1991).

Sense of security- Granting the mothers security is also important in enhancing the communication process. Women can contact midwives in the One-to-One model whenever needed to ask questions or to gain information. This availability and readiness enhances the women's sense of being secure or 'safe'. It encourages communication because women are at greater ease and do not feel guilty when needing to contact someone at any hour of the day (Tinkler & Quinney, 1998). This sense of security may, in turn, decrease the woman's vulnerability and allow for more open, fluid communication and ease with the midwife (Tinkler & Quinney, 1998).

Reciprocity is the basic social process that embraces the whole midwife-client relationship where ideas are exchanged, developmental goals are achieved and compromise may occur (Fleming, 1998). The shared control and mutual decision making between the midwife and woman leads to achievement of common or shared goals (Kennedy, Rosseau, & Low, 2003). Through interviewing a large sample of midwives and clients from New Zealand and Scotland, Fleming (1998) discovered that reciprocity was expressed in terms of bringing together aims and aspirations to create the reality. The researcher goes on to say that so long as midwives acknowledge and respect the knowledge each client has of her body and the changes within, reciprocity will occur. The continuity provided by caseload practice was the basis for a highly reciprocal relationship valued by midwives as much as mothers (Beake, McCourt, & Page, 2001).

Friendship is a personal relationship between two parties that involves intimacy and emotions (McCrea & Crute, 1991; Walsh, 1999). Midwives face the inherent challenge when forming a relationship with a mother of keeping and managing boundaries, or maintaining professionalism. The focus should be on the mother, and

although the midwife and mother may be communicating for about ten months, the midwife needs to be mindful that the relationship is professional and thus must be kept time-limited (Walsh, 1999). In a study by McCrea & Crute (1991), midwives reported that being totally 'professional' was a response to difficulty in establishing a relationship with clients. In this particular study, the midwives struggled with the notion of defining professionalism as 'detached, objective, and in control' when applied to emotional involvement. The midwives felt that a lack of emotional involvement lead to a deficit in practice and emotional work was needed to 'do their job properly.' When midwives hesitated in responding emotionally, they looked on those relationships as 'poor'. The researchers came to the conclusion that if midwives are committed to providing holistic care, then being emotionally involved must be given high priority, but on a level that does not cloud objectivity within the relationship.

Intimacy- Many parallels have become apparent between an intimate relationship and the midwife-mother relationship. The model of intimacy conceptualized by Dimen, 1989, as cited by Fleming (1998) explains that each creates the other through 'knowing, sensing, and intuiting the other at the boundaries between the two'. It indicates a willingness to display commitment and involvement from both the midwives and clients (Fleming, 1998). In order to achieve an intimate relationship within the realms of professionalism, however, midwives must be aware of their own feelings about themselves before being able to establish any kind of relationship with clients (McCrea & Crute, 1991). Kennedy, Shannon, Chuahorm, & Kravetz (2004) also emphasized that being close with the woman requires being open to her, what she brings to the relationship, and, at times, entails personal disclosure.

Dependency occurs when either the midwife or mother feels as though he/she cannot function without the input or presence of the other party. This is important for the mother who needs to realize she can give birth herself, and for both parties who must eventually end the relationship. The midwife can take action to avoid this by not providing total care. She must achieve a balance of acting as facilitator and enabler rather than creating dependency. This involves being a leader when needed but allowing the mother to use her knowledge of her body to make decisions. The midwife avoids dominating the relationship by working together in partnership with the mother. Tinkler & Quinney (1998) found that support was most welcome among interviewed women when it was perceived to be enabling as opposed to interfering and dominating.

Midwife grief is a broad term used to describe the way the mother may feel after ending the relationship and coming to the realization that the midwife she has seen and grown close to for the last nine months is now out of her life. Walsh (1999) discovered through an ethnographic study that women reported feeling abandoned and sad after terminating the significant relationship postnatally. Many found ending contact difficult and did not maintain the needed sense of detachment due to the time-limitedness of the relationship. Ending the relationship without dependency decreases the likelihood that midwife grief will occur, but what steps do midwives take to prevent this?

There is a paucity in the literature concerning midwife grief. Walsh (1999) comments "there are no published studies in the context of the midwife/woman relationship that highlight the concerns about ending relationships with midwives" (p.173). There is also no study comparing whether there is more midwife grief in one model of care such as One-to-One and another model such as standard care.

In summary, the literature highlighted eight key components of the midwife-mother relationship. These themes were respect, communication, sense of security, reciprocity, friendship, intimacy, and dependency, and grief. The themes served as a guide during the construction of a semi-structured interview, observation of U.K. midwives, and subsequent analysis of findings.

Methodology

Two data collection methods were chosen for the project- a combination of semi-structured interviews and observation in hopes of producing rich data. Interviews, in comparison to quantitative methods, tend to provide rich data in midwifery research because they allow for more in-depth information (Rees, 1997). Semi-structured interviews describe in detail the nature of the relationship as experienced by the midwife. Interviews have a particular relevance in midwifery as they provide an opportunity to pursue a woman-centered approach to issues and situations (Rees, 1997). The One-to-One model stresses this approach through practice, so it was thought appropriate for this research. The eight relationship themes also reinforced the need for the semi-structured interview questions to be open-ended because of their qualitative nature. The interview consisted of three closed questions and nine open-ended questions. Midwives were interviewed after being observed in order to control for biased behavior. The interviews were tape recorded and subsequently transcribed by the researcher.

Observation adds breadth to research and provides answers to contextual questions that cannot be answered by interview alone (Rees, 1997).
There are four ways of observing, and "observer as participant" was utilized while in the U.K. In this form, the researcher is in the setting but does not have any real involvement

with the activities that take place. The emphasis is on the evident observation (Rees, 1997). Observation was deemed useful because the student researcher may be aware of more noteworthy events and language because she is an outsider. Researchers who have spent a lot of time in midwifery research may stop seeing particular activities as noteworthy due to expert bias. The researcher becomes overly familiar with the research setting and no longer notices the kind of elements that need to be included in the observations (Rees, 1997). Observation was focused on relationship factors that were previously mentioned, with the researcher taking note if and how they were observed.

Instruments

The researcher-designed tools were compiled for guidance and organization during the observations in accordance with the review of literature. The language within the tools was adjusted per audience, depending if they applied to the midwives, the women, or solely the researcher. Appendix A is the first part of the Observation Record for the study in which the student researcher assigned an identification number to the observed midwife and took note of start and end time as well as hospital setting. This record was used to document any noteworthy actions or sayings that took place during the observation. Appendix B served as the second part of the Observation Record during the observation. Prior to going to the U.K., the student researcher created the Observation Record with the eight themes and hypothesized actions that could fall under each category. For example, under the theme "Professionalism vs. Friendship," actions included maintenance of boundaries, sharing of personal information, and visits focused on the mother, not the midwife. Each time an action was observed, a check mark next to the action with a detailed specific description was recorded. The semi-structured

interview can be viewed in Appendix C, reflecting both closed and open-ended questions. Appendix D is the Informed Consent that each midwife read over prior to agreeing to participate in the study. Appendix E is the E-mail recruitment script that was utilized when recruiting midwives prior to the beginning of the study. Lastly, Appendix F is the script that was used to gain permission from the mothers prior to observing their midwife provide care for them.

Timing

The postnatal period (birth- 42 days) was chosen because during the initial review of One-to-One care, the rate of satisfaction with postnatal care was the lowest of the three aspects of maternity care (antenatal, intrapartum, and postnatal) in the U.K. (CMP, Retrieved 1/3/2005 from http://www.wolfson.tvu.ac.uk/cmp/oneto onesummary.html; Singh, 2001). Home-based maternity support is a prominent aspect of midwifery care in the U.K. (Declercq, 1998). Care provided in the home offers individuality, comfort, and familiarity, and can be seen as a choice and thus a source of empowerment by women (Spurgeon, Hicks, & Barwell, 2001). Under normal circumstances, postnatal home visits are once a day for about ten days. The midwife continues to visit the mother and baby for a maximum of twenty-eight days. Normally she visits daily for ten days and then less frequently, provided the mother and baby are doing well. Between ten and twenty-eight days of postpartum care, a health visitor, a Registered Nurse (RN) who has completed a minimum of three months of obstetric experience and a one year post-registration course, takes over for the midwife until the sixth week postpartum, visiting as needed (Story et al., 1996). The postnatal mothers the student researcher encountered ranged from just having given birth to 6 days postpartum.

Sample

First time mothers were chosen because they have the most need and vulnerability, and it was believed that the researcher could analyze a fresh, new relationship more readily. The midwife may also treat experienced mothers differently based on their previous relationships or knowledge.

Before traveling to the U.K., midwives from a total of thirteen institutions (ranging from large hospitals to small birth centres) were contacted via e-mail recruitment (Appendix E). Five representatives from those thirteen institutions replied, four with interest in participating in the research study. The remaining midwives that did not reply were sent an additional e-mail whilst the researcher was in the U.K. in order to increase sample size, but no replies were gathered. Of the four interested institutions, two were major tertiary hospitals and time constraints prevented the student researcher from obtaining institutional ethical clearance. The remaining two contacts resulted in a convenience sample of a total of three midwives (See Table 1).

Table 1

Participating Midwives	Model of care practiced
Midwife 1	*Standard- hospital (birth centre)*
Midwife 2	*Standard- hospital (birth centre)*
Midwife 3	*One-to-One- community*

Two hospital midwives were observed and subsequently interviewed at a midwife-led private birth centre. Between Midwife #1 and Midwife #2, the student researcher observed postnatal care with one mother immediately after birth. Seventeen hospital midwives lead the birth unit and the midwives attend an average of five hundred births per year. Labor is a One-to-One model, while antenatal and postnatal care is a team approach. Mothers spend an average length of 2-3 nights in the unit postnatally

before being sent home, where a separate community midwife (assigned to them by district) then takes care of them.

One community midwife (Midwife #3) was observed and subsequently interviewed from an NHS affiliate located on an island in the U.K. This particular midwife follows a true One-to-One model of care, with a personal caseload of 76 women cared for from the antenatal to postnatal period. She works with two other midwives who act as her back-up if she cannot attend to the women in her caseload. The student researcher observed the community midwife (Midwife #3) providing care to a total of 17 women, two of which were 6-day postnatal visits.

The ideal was to solely observe postnatal care provided by the midwives for the first-time mothers. However, because of the convenience sample and limited days of research, the student researcher agreed to observe both antenatal and postnatal visits with the community midwife, a breastfeeding class taught by Midwife #2 with mothers preparing to give birth, and observed both first-time mothers and mothers who had previously given birth. As antenatal observations were not included in the approved study protocol, no data were collected on the observations during antenatal visits, but field notes were recorded.

Data analysis

The information collected was analyzed to establish themes, with an attempt for themes to be mutually exclusive. This is the process of content analysis (Morse and Field (1996) as cited by Rees, 1997). Content analysis is the process of understanding, interpreting, and conceptualizing the meanings in qualitative data (Macnee, 2004). The researcher starts by breaking down the data into units that are meaningful and then

develops a categorization scheme. The scheme is based on the ideas found in the data. For this particular study, pieces that reflected the existing eight key themes were put into categories in a process of coding. Data that did not belong to any of the eight categories were grouped separately and new themes were discovered. There was some overlap of categories/themes, but data saturation did not occur due to the small sample size.

Once the student researcher arrived back in the United States, the interview tapes were transcribed verbatim. The transcribed interviews were then thematically content analyzed. They were read and re-read for common themes that were in accordance with the previously eight identified themes as well as themes that differed or were novel from the literature review. A quality assurance check was completed by two nursing professors of the student's committee who have a background in qualitative research. After reading the transcribed interviews and offering their suggestions and insights, a list was generated with the common themes and subsequent appropriate quotes.

The recorded notes from the observations were reviewed for connections to the eight identified themes. The observation records (Appendices A & B) were reviewed once the student researcher returned to the U.S. for similarities and discrepancies with the interviews.

Findings

After the data from the interviews and observations were analyzed, the findings were organized into four separate categories based on relevance to the purpose of this study and actual outcomes. Section 1 describes the relationship content of the interviews along with significant quotes provided by the midwives. The researcher observed that the setting affected care, which is described in Section 2. Section 3 outlines differences

between the two models of care based on observation and opinions of the midwives. Lastly, Section 4 is a secondary analysis of the One-to-One model of care and its effect on the midwife-mother relationship due to the large amount of data gathered from the community midwife in two different settings.

1) Validation of 8 Relationship Themes through midwife interviews

All midwives answered the entire interview, with a time duration ranging from 10 to 25 minutes in length. Years of practice ranged from 7-11 years. All have practiced standard midwifery during their careers, but only midwife #3 had experience with and currently practices One-to-One midwifery.

In every interview, all midwives touched on and expanded on the eight themes identified from the literature search, which are described in detail below. An interesting finding was the high level of interconnectivity between the themes. Statements could often fall into more than one of the eight categories.

Respect- The midwives recognized that the woman is at the center of care, but the midwife is also caring for the woman's family. Other aspects of respectful care included maintaining a safe and secure environment and being timely.

Midwife #2:

"It's not just knowing her, it's knowing her family. It really is.

You have to respect that woman and her partner."

Midwife #3:

"You usually build that fairly quickly, the trust, simply by turning up when you say you're going to.

You give them the time they need and you're not rushing them at any stage."

Communication- This was a vital component of midwifery care expressed by the midwives. Healthy communication led to an improved relationship between the mother and the midwife, and all midwives stressed the importance of being aware of the communication process in practice. Within the concept of communication, encouragement and reassurance were seen as inherently essential.

Midwife #1:

"The midwife should communicate and articulate well. [T]he midwife should offer support and reassurance...It's important to have feedback to assess how the relationship is going, and you get feedback in lots of different ways (not just vocal)."

Sense of security- Whether it was standard or One-to-One care, the women were made well aware that they had access to a midwife whenever they needed one, and to not hesitate to call if they had a question or concern. This demonstrates trust and leads to increased communication with the midwife (Tinkler, 1998).

Midwife #2:

"It can be quite frightening at home during the night, particularly if they have no family or help at home, and there is a midwife here 24 hours a day on the unit. Many mums take advantage of this and call, requesting the midwife that they know."

Midwife #3:

"I feel that you should build a relationship so they feel they can confide in you.

When they do call you, reassure them that it's fine that they called you. The more you do that, the more open they will be with you...Once you've got a relationship, they will tell you anything."

Reciprocity- this theme was achieved in practice amongst the midwives through therapeutic communication. Midwife #1 highlighted this by assessing what the woman needs at all times and evaluating the feedback received from the mother. Reciprocity

seemed to be the underlying key ingredient for the relationship to proceed. Without reciprocity, the relationship becomes stagnant.

Friendship- The midwives felt very strongly that they needed to keep the relationship with the mother on a professional level. This is achieved through boundary setting, communication, and respect. An overly-friendly relationship was seen as unhealthy and placing the mother and/or midwife at risk for dependency. Within being professional, however, it was important for the women to see the midwife as a real human being.

Midwife #1:

"The midwife needs to be professional about the relationship.

It is hard when looking after a friend. I did that once, and you do become emotionally attached, which makes it worse and harder to break away. You need to be objective and not have more than a casual relationship.

You need to make sure that [dependency] *doesn't happen because it is a professional relationship."*

Midwife #2:

"However friendly you get with somebody it's still a professional relationship you've got... We use first names here, which is nice, and it makes you feel much more friendly, but you have to remember they are not friends, they are clients."

Midwife #3:

"You want them to see you as the midwife, as the professional. You also want them to see you as a human being that they can talk to and that they have confidence in... That's the most important thing, that they can see that you are human, that you are real."

Midwife #3 stated that she will attend christenings she is invited to, but "when offered to come have drinks, I don't take them up on that offer. It is not professional."

Intimacy- all three midwives were well aware of their own feelings about the degree of intimacy a professional relationship should entail (the first step before the establishment of a relationship being defining one's own feelings). They believed relationships can be intimate without creating dependency in the mother or the midwife, and a bidirectional connection facilitates that intimacy. Perhaps midwife #2 describes it most eloquently:

> *"I think a sort of empathy between the mother and the midwife, then that is probably the best thing."*

Dependency/Grief- These two themes were merged because the researcher heard the midwives express that dependency on the mother's behalf leads to midwife grief. In order to avoid dependency, the midwives stressed that a role of the midwife is to be a facilitator for the woman by inspiring a sense of confidence in her, which leads to the goal of independence. If the midwife feels herself becoming attached or sees dependency in the woman, she will often request that another midwife care for her. Strategies used to prevent grief in both parties include staggering and spacing postnatal visits, encouraging the mother to attend a postnatal group, and verbally preparing them for the end of the relationship.

Midwife #3:

> *"You praise how well they are doing positively, that they can manage it and they are doing fine."*

Midwife #1:

> *"You have to take the time to make sure they are willing to let go…ultimately, you don't want anyone to have that* [dependency]- *they need to have the confidence to move on themselves…this is done through positive reinforcement, education, and not doing things for them. They are the ones in control and should be self-sufficient. If there is dependency, I believe the relationship has failed."*

Midwife #1 also provided an interesting perspective when asked what she does to prepare herself for the ending of the relationship:

> *"I don't really see it as an ending of a relationship because you are preparing them for the next stage- for that transition to go. Although the relationship may close, in a sense, you are happy to see them go."*

Midwife #2:

> *"The thing is with being a midwife, there will always be another person going to come along.*
>
> *I think the cutoff point is probably easier for us than with the One-to-One model."*

Midwife #3:

> *"I try very hard not to foster it* [dependency]. *I've seen it start to develop with women and what I do, since working in a team, is I tend to pass her along to someone else for a visit or a couple visits and it tends to break that sort of spell. I've seen it foster with one of my colleagues where women are sobbing and weeping and to me that is not a healthy relationship and I will not have that.*
>
> *You have to stop it* [dependency] *very quickly because it's harder when someone is dependent on you and you don't want to make it any worse than what it is.*
>
> *Most of the time, you can see it building and see the warning signs. The dependency happens when they think they can't do it. The midwife should be encouraging them to be independent and doing it themselves.*
>
> *After the 7 day weigh-in, then we start to stagger the visits quite substantially... If I think that someone is getting a bit clingy, I will prepare them by saying, "At the next visit, I'm going to look at discharging you." If it's someone who is not too clingy and doing particularly well, then I give them the option if they want me to come back again or to discharge that day. But I always give them the option. I don't give them any set time I'm going to sign them off- it will just be when they are happy, I will. I don't let them go until they are happy.*

As will be seen in later sections, midwives in standard care felt that the One-to-One model of care would lead to increased dependency because of the stronger relationship built with the midwife. However, these are outsiders' perspectives, and Midwife #3 did not find that women are clingier in the One-to-One model. The

researcher noted that when asking the midwives what they do to prepare themselves for the ending of the relationship, all three had a look of surprise, as though no one had ever asked them that before. However, all midwives acknowledged that it is not just the mother who can be affected by the ending of the relationship, but the midwife too.

Additional Themes Identified

In addition to what was supported by the literature, four new themes emerged. More research will be needed in the future to validate them as relationship factors. The most commonly mentioned new theme among the midwives was how the **personality** of the mother can affect the relationship. There seemed to be a consensus that if a midwife does not "click" with the mother, the relationship will not be as beneficial and the midwife will seek a different midwife to work with the mother in order to facilitate a better relationship. It is human nature to not get along with everyone encountered, especially in a health care setting. The following comments reflect this:

Midwife #1:

"It is important, I think, to have a connection, and if you feel like you're not really connecting (you cannot connect with everyone because of different personalities), we may perhaps bring in another midwife and they could establish a better relationship.
I think you get it [feedback] *if you connect with somebody…some mums are needy and may turn to their partners or husbands, while others are self-contained."*

Midwife #2:

"Your personality is bound to click with one midwife and with one woman better than others. We always say to them if you work with one midwife more often and you prefer to be looked after by her, then that is absolutely fine…If the midwife is having problems with the woman and they can tell it's not going right, they will ask another midwife if they mind looking after her ("I don't know, whatever I say, she doesn't seem to click"). It's human nature for not everyone to have chemistry with each other…

It's much more helpful for those mums who have met their midwife before labor than meeting someone completely fresh. You know their personalities really well then.

My only thing with the One-to-One is that if the woman doesn't actually hitch up with that one person or they fall out, that can be a downside to it.

I think with some people it's [ending the relationship] *harder than others just because of personalities."*

Midwife #3:

"I've learned now not to judge as quickly as perhaps I did because by the end of the pregnancy, you might really like the person when initially you didn't...that would not happen in standard care simply because there is not enough time and shorter spaces of time to complete it in.

Sometimes you do click with someone very much so and if you want to have a friendship later on, there's no reason not to.

Every woman is different.

It (having a relationship) can be difficult because you can have someone who is quite quiet or who doesn't like being the center of attention and can be quite shy."

Another aspect of personality that could be considered more in depth is that of the midwife's. There is more anonymity in the hospital, which may be preferable to some midwives. In a community setting, especially a small one as was observed on the island of the U.K., the midwife was a familiar face to many women walking on the sidewalks or driving in their cars. The personality of midwives may play a role in how they choose what setting to work in. A more extroverted midwife may choose the community setting, whereas a more introverted or self-contained midwife may choose a hospital.

Another theme that is inconsistent with the RCC framework was the emphasis the midwives placed on being **selfless**. All felt the mother should come first in the relationship, with the midwife focusing on the mother's needs yet being aware of her own concurrently. This was demonstrated in the interviews:

Midwife #1:

"I think the midwife should assess what the woman needs at all times."

Midwife #2:

"You need to recognize that you are not perpetuating your own needs- you should be meeting hers."

Midwife #3:

"You are their advocate and out to get the best thing for them.

You do have to be selfless and flexible.

It's making them feel that my time is theirs at that moment in time.

For me, I will go the extra mile if I have to because it's for the benefit of the people I am looking after…At the end of the day, if I made them feel better, I've done my job. If I haven't made them feel better, I'm not doing the job I should be doing."

A third major theme that emerged was how the level of a **sense of vulnerability** in women affects the relationship. The traditional definition of vulnerability being a state of helplessness and susceptibility may not coincide, but was derived from the midwives' language. Hagerty & Patusky (2003) discuss the importance of role expectations on the part of the nurse when entering a relationship with the mother. Nurses "identified vulnerability of patients as an essential foundation of nurses' abilities to 'connect' with patients…Nurses take for granted that patients 'should' want to participate in building a relationship" (p. 147). Although nursing and midwifery are two different disciplines of practice, one can easily see how this can also pertain to midwifery care. In addition, the midwives provided evidence:

Midwife #2:

"With breastfeeding particularly, they are vulnerable and want to talk to you only, particularly if they are having trouble. I think the downside is, they won't

trust as much the other professionals who are out there who are as well trained as we are."

Midwife #3:

"It's the fear of going into the unknown [labor]. *Multips, you generally don't see it. It's more with primips because they have never been there before and are worried of doing something wrong. It's just a case of reassuring them."*

A sense of vulnerability may make it easier for the midwife to offer herself to the mother and form a relationship, but it also has the potential to lead to dependency. The midwife must reassure the mother that she can do this herself and give her the confidence and encouragement she needs to be in control of the situation.

The fourth additional and interesting theme was the **negative impact of the NHS on midwifery care**. Even though the midwives were not asked specifically about their feelings of NHS care, all commented on it specifically in the final open-ended question when asked if they had anything else they would like to contribute.

Midwife #1:

"There are not as many staff or time pressures here in private care. It is definitely worse in the NHS. We get to know the women more in-depth here. In the NHS, you only get to know them on the surface level. There is no time to develop the relationship further, and it is not as satisfying working as a midwife. Often times on the ward there may be only two midwives for forty women."

Midwife #2:

"We need the government to recognize the need and importance for midwives. A lot of us have moved to the private sector. We've all worked in the NHS and we all found that we weren't getting job satisfaction. We were getting used."

Midwife #3:

"I think it's important that the government doesn't try to standardize care into how many visits- it's a statistical thing and I don't think you can...At the end of the day, we need to look at the overall picture and not the short term...The targets are not practical- every woman is different, and it is all relative."

The overall consensus is that the midwives enjoy having more time to spend with the mothers to build relationships. They do not feel as pressured with constraints as they would in standard NHS care and are more satisfied professionally. These comments raise the awareness that health care systems can disrupt and frustrate Relationship-Centered Care (RCC). The following section discusses how the setting affects the relationship between the midwife and mother during maternity care.

2) *Assessing how the setting affects postnatal care & the impact on the relationship*

One standard postnatal visit in the hospital was observed and two One-to-One postnatal visits in the community. The most striking observation made was the difference in the amount of time spent with the mothers between the two settings. In the hospital, the observed postnatal visit lasted for 25 minutes, and the midwife was entering and leaving the room throughout the visit. In the home, the first postnatal visit lasted for 35 minutes and the second for 40 minutes. The midwife devoted the entire time to the mother and her concerns, never leaving her side until the mother was satisfied with the visit.

The informality of using first names was present in the One-to-One care observed, whereas in the hospital the midwife did not know the name of the mother or the father, and when she did, she did not use their names to address them. This demonstrated higher intimacy and respect within the home setting.

The atmosphere in the hospital and the home were also different. There was a much more relaxed air about the home visit. The mothers are in a familiar environment and have grown accustomed to having the midwife enter their homes for the past nine months. Distractions in the home were less than the observed distractions in the hospital.

In the home, distractions included the television and small children. In the hospital, distractions included other professionals wishing to speak with the midwife or the mother, food service, telephone calls, cleaning of the room, and a small amount of space in which to work. Midwife #1 did take care to maintain a respectful environment in the hospital by keeping the door closed and providing the mother with personal privacy (draping her, etc.).

3) Analyzing the difference between the models of care

The main observation made by the student researcher between the two models of care was that there was more time and increased attention to the mothers in the One-to-One model of care. However, the midwives gave conflicting views on how they perceived the care between the two models. Midwife #1 stated,

> *"I think you will find that the clinical care, the care itself, and meeting the woman's needs between the two models is the same."*

This comment states that the practice of midwifery knows no boundaries- the midwife will provide the same care regardless of the model she is using. However, Midwife #3 offered the following opposing statement:

> *"I've had experience with the standard model as well, but it is not as good. Women who get transferred into One-to-One feel cheated because the care* **is** *different between the models."*

The above comments may be seen as biased due to familiarity with only one model of care, but Midwife #3 had experience in both models. She also disclosed the following when asked about the difference between standard and One-to-One:

> *"You have to do the same things* [in standard midwifery] *but in a much shorter space of time because you have to build that trust, that confidence, in that one meeting and at that moment that you are looking after them."*

What we can gather is that the core elements of midwifery care are the same in the two models, but the way they are implemented are affected by setting and time available. Midwives strive to offer care that is consistent with their views on midwifery and what they have grown accustomed to practicing no matter what practice setting or model they are in. The woman continues to come first in practice, and the midwife must adjust her practice in order to meet the woman's needs.

The midwives were professional with the mothers and all midwives acknowledged the importance of maintaining boundaries in the relationship, regardless of model used. They all stressed the importance that the women are clients, not friends. Midwife #2 voiced her opinion on this issue with the two models of care:

> *"Maybe with One-to-One that* [being over familiar] *could be harder because you go to their houses and get sucked into their families like that... we aren't seeing them as much as in the One-to-One, so I think the cutoff point is probably easier for us than with the One-to-One model... I think you're more likely to burnout quicker* [in the One-to-One model]*."*

Again, this comment comes from an individual who has not had personal experiences with the One-to-One model of midwifery care. Midwife #3 did not feel that One-to-One care leads the midwife and mother into an overly friendly, unhealthy relationship. She also felt that this model was very rewarding to her professionally and even more so to the mother.

4) *An ancillary analysis of One-to-One midwifery and how the particular setting affects the relationship*

Due to the wealth of information accumulated with the One-to-One midwife, including being exposed to antenatal visits both in the home and in her clinic, the decision to include an ancillary analysis of this model with pregnant women was deemed necessary. In the home, two postpartum and three antenatal visits were observed. In the

afternoon, in the clinic, a total of twelve antenatal visits were observed and subsequent field notes were taken.

The home visits were previously highlighted. In both settings, communication was clearly evident with the midwife. Many women had elaborate birth plans typed up that they provided the midwife in order to avoid any misconceptions. In the clinic, Midwife #3 states that she takes care not to watch the clock, and the visit with a woman does not end until the woman is satisfied. She takes great care not to rush them, and if she must stay longer during the day unpaid to see all the women, she does:

> *"It's making them feel that my time is theirs at that moment in time. And they know I am there for them at that moment- not clockwatching. For me, I will go the extra mile if I have to because it's for the benefit of the people I am looking after, even if I'm only getting paid until 5:00* [6:30 at time of interview]. *Being a midwife is not a job, it is a profession...you do have to be selfless and flexible."*

It was interesting to witness the differences between the clinic and the home settings. In the clinic, more women were seen during earlier pregnancy stages. In the home, the three antenatal women were close to their planned delivery dates. These women had a much more fluid conversation with the midwife, with the atmosphere being more relaxed and there was more familiarity with the midwife. Midwife #3 comments on this:

> *"Once you've got a relationship, they will tell you anything and they'll give you things without you having to fish for them; but initially, you're fishing, and it's how you answer the questions that they're finding it difficult to ask depends on how much information you will get."*

Of the 12 clinical visits, four are noteworthy from the analysis because they highlight how the midwife assesses and adjusts the relationship with the woman in order for it to be most therapeutic. These women presented to the midwife with unique needs that required special attention. The other eight women were routine antenatal visits, with

less time being spent with them and the elements of care consistent. A young pregnant teenager came for a visit and the midwife adjusted her tone for the teen. In the interview, she comments on this:

> *"The teenagers tend to like me more because I'm nearer their age. I have one teenager that texts me all the time. When you talk to them on their level, I think it makes a big difference. You are on their side and you are their advocate and out to get the best thing for them. You get them to stop saying "I can't do this."*

Many themes can be identified in the above comment, including communicating with the teenager in a way that is most appropriate for her (including text messages), being an enabler/facilitator by stressing advocacy and encouragement, and respect by validating the teen's efforts.

Another visit involved a foreign pregnant couple, where the husband could speak English but the woman could not. The midwife looked at the woman as she spoke, but the husband would not relay anything that was said to his wife. The midwife explained that this poses a definite barrier to the relationship with the woman because of the lack of communication, intimacy, and reciprocity:

> *"Women who have really dominant partners who answer for their wives make it increasingly difficult, especially when they* [the women] *don't understand the language. It makes it hard. I try to look at her, but she's not understanding anything I'm saying."*

The last visits, which were unscheduled, included a mother who was in an abusive relationship and a mother whose husband was rejecting their child and going through postnatal paternal depression. Both came just to talk with the midwife and discuss their problems, coping skills, and solutions. The midwife listened readily and worked with the mother to ease her concerns and encourage positive coping skills. These mothers obviously felt a sense of security with Midwife #3 and reciprocity was evident.

> *"They know where you are and know they can stop in and say hi at any time if they want to."*

The latter mother, however, spent almost an hour with the midwife, crying and repeating many of the same things. The midwife disclosed to the researcher after the woman left that that was a borderline, unhealthy relationship because the woman was clearly displaying some dependency tendencies. The midwife explained that if she were to come in again in such a state, she would recommend that the woman see someone for counseling because those issues are outside of the midwife's role and would put the relationship at risk.

Discussion

The study highlighted important themes that midwives everywhere can take into consideration when forming, maintaining, and ending the relationship with the mother. The amount of time and the state of relaxation in the care setting the mother perceives she has with the midwife can affect postnatal care. The mother may be prone to feeling more comfortable asking questions as a result of these two factors, which can lead to improved care of the newborn. The student researcher noted that many more questions were asked in the home as opposed to the hospital. There was a greater amount of intimacy in the home. The amount of intimacy in a setting, not just the relationship, can subsequently affect postnatal care.

What was not observed but what midwife #2 disclosed in her interview was the importance of a postnatal group for the mothers. The birth centre offers a postnatal support group, *"which is for mums really as long as they want to, but usually for 6 months to a year…that's a natural progression that they would go to that as opposed to keep calling us."* In the One-to-One model of care, however, the mother does continue to

contact her midwife as needed and postnatal visits may occur for up to six weeks. Mothers in the standard setting may benefit from the different dynamic of having a group of mothers to speak to instead of a single midwife to share concerns that they may not address with the midwife.

The initial review of literature highlighted the importance of continuity of caregiver during maternity (Page, 2003). The midwives agreed that it is enjoyable to build on relationships formed with familiar faces, but they did not mention "continuity" in any of the interviews. One can expect that the perceived importance of continuity of caregiver would have been mentioned by women receiving midwifery care because they are the ones directly affected. However, this study did not focus on the mothers' ideas, thoughts, and feelings related to midwifery care, so this topic was not addressed.

In regard to midwife grief, the above suggestions, comments, and thoughts can benefit midwives practicing everywhere, no matter what type of model is being used. The beginning of any relationship also has its ending, and in order for it to be therapeutic and beneficial, dependency and grief must be avoided.

Limitations

The limitations of the study included the small convenience sample, consisting of only three midwives and six recorded observations. Field notes from midwife #3's twelve antenatal clinic visits and women who were not first-time mothers were included in the study to add depth to the findings. There are also limitations involved with the data collection methods. It is not possible to observe and record everything. Some details will inevitably be observed and others left out (Rees, 1997). A limitation with the semi-

structured interview tool (Appendix C) is that interviewing relies on what the person says, not necessarily what they truly think or feel (Rees, 1997).

The findings cannot be generalized beyond midwives practicing or mothers receiving One-to-One or standard care in the U.K. The organization of the original study has potential to be expanded upon in the future and could be easily replicated with a larger or different population within other settings.

Lessons learned

When doing international research, the researcher should take heed to obtain clearance from their particular university or institution six months in advance of traveling abroad. The student researcher did not contact institutions in the U.K. before obtaining Human Subjects Institutional Review Board (HSIRB) clearance from Western Michigan University. Once abroad, the student found it difficult to obtain ethical consent within one month from the desired institutions. When meeting with the head of midwifery at a Birthing Centre, the midwife said it takes an average of six months to obtain clearance from the greater hospital. More clear communication via telephone would have perhaps disclosed this fact to the student researcher.

Secondly, contacts and dates should be established before going abroad. The student researcher found it difficult to try to gather contacts in a short amount of time and rely on the assistance of others whom she was not familiar with. Also, unforeseen events can occur and did. On one particular day when the student researcher was scheduled to have a meeting with midwives at the Royal College of Midwives, the first bomb attack on London tubes and buses (July 7, 2005) occurred and disrupted planned proceedings.

Thirdly, e-mail should not be the only source of recruitment. Phone calls should have been made to the U.K. prior to visiting and more should have been made while abroad. Again, e-mail is efficient, but unforeseen events can hinder a researcher from accessing the Internet (as in the case of the London bombings). Also, the return time varies with e-mail, whereas with phone conversations, it is timely and direct. Another option would have been to go straight away to the desired sites and ask to speak directly to someone who would consider the study.

Recommendations for future study

Questions to be asked for future research include: what techniques that midwives use to end the relationship are found most beneficial by mothers? How do midwives who give birth themselves perceive the care from a One-to-One model or standard care? Is there more conflicting advice given postnatally in the standard model, and how does this affect the relationship with the midwife? How do mothers who have received maternity care in both the United Kingdom and the United States rate their experience? How do midwives balance the fine line between being personal with the mother in order to enhance intimacy but avoid a "professional as friend" relationship? A study could be devised that controls for setting and time with the researcher interpreting which factor plays a greater role in the midwife-mother relationship. Replication of the study with a broader group of midwives and mothers could also be done in order to gain further insight into the relationship phenomenon among different models of care.

Conclusion

Although the study did not go exactly as planned, insights were gained and four additional relationship themes were identified. There was some overlap of categories in

the interviews, such as friendship and intimacy, as well as respect and communication. The student researcher organized the data according to the theme it most closely coincided with on the Observation Record (Appendix B). Perhaps one can speculate that the art of midwifery practice leads itself to midwives fulfilling multiple roles and duties simultaneously. Information gathered supported the evidence from the review of literature and added to the body of nursing knowledge as it relates to models of midwifery care. Midwives around the world can consider the information that was provided with the total twelve themes to guide their practice and subsequently adjust it to best meet the needs of the woman and build a healthy, therapeutic relationship.

Relationship-centered care (RCC) was reflected via observation and interviews because the relationships between the midwives and women were valued and attended to. The only exception was the theme of being selfless, which does not fit into the core level of "self" within the model. Again, this study cannot be generalized outside of the U.K., and this theme may not occur in a different setting, country, or model of midwifery care.

The focused theme of midwife grief is an important concept to consider because the midwife-mother relationship, in order for it to be therapeutic, must end on a positive note. The mother needs to feel that the relationship has come to a close without feeling abandoned or experiencing a great sense of loss at a time when she is vulnerable to her new lifestyle (Walsh, 1999). Midwives must take heed of this concept and apply it to practice.

The description of the One-to-One model of care and the standard midwifery care in the U.K. and how both affect the relationship between midwives and mothers in the postnatal period reaffirmed the existing themes identified in the literature and provided

additional new themes. Based on the interviews and observations, different variables such as time and setting affect the relationship in both models. The data from this study suggest that the One-to-One model provides midwives with more time to form and maintain the relationship with the mother, while the basic midwifery care in both models is the same.

References

Battersby, S. (2001). Research & review. Midwifery and research; comparable skills in listening and the use of language. *The practising midwife, 4*(9), 24-5.

Beake, S., McCourt, C., & Page, L. (2001). Evaluation of One-to-One Midwifery: Second Cohort Study. London: NHS. *The Hammersmith Hospitals Trust TVU,* 1-78.

Centre for Midwifery Practice (n.d.). *Evaluation of One-to-One Midwifery Practice Summary and recommendations.* Retrieved January 3, 2005 from http://www.wolfson.tvu.ac.uk/cmp/onetoonesummary.html.

Declercq, E. (1998). Changing childbirth in the United Kingdom: lessons for U.S. health policy. *Journal of health politics, policy, and law, 23*(5) 833-859.

Fleming, V.E.M. (1998). Women-with-midwives-with-women: a model of interdependence. *Midwifery, 14,* 137-143.

Graef, P. (1988). Postpartum concerns of breastfeeding mothers. *Journal of nurse-midwifery, 33*(2), 62-66.

Hagerty, B.M. & Patusky, K.L. (2003). Reconceptualizing the Nurse-Patient Relationship. *Journal of Nursing Scholarship, 35*(2), 145-150.

Hicks, C., Spurgeon, P., & Barwell, F. (2003). Changing childbirth: a pilot project. *Journal of Advanced Nursing, 42*(6), 617-628.

Hunter, B. (2000). The emotional work of being a midwife. *The practising midwife, 3*(2), 34-6.

Kennedy, H.P. (2000). A Model of Exemplary Midwifery Practice: Results of a Delphi Study. *Journal of Midwifery & Women's Health, 45*(1), 4-19.

Kennedy, H.P. (2002). The Midwife as an "Instrument" of Care. *American Journal of Public Health, 92*(11), 1759-1760.

Kennedy, H.P. (2004). The Landscape of Caring for Women: A Narrative Study of Midwifery Practice. *Journal of Midwifery & Women's Health, 49*(1), 14-23.

Kennedy, H.P., Rousseau, A.L., & Low, L.K. (2003). An exploratory metasynthesis of midwifery practice in the United States. *Midwifery, 19*, 203-214.

Macnee, C.L. (2004). *Understanding Nursing Research: Reading and Using Research in Practice.* Lippincott Williams & Wilkins: Philadelphia.

Mander, R. (1997). Choosing the choice in the USA: examples in the maternity area. *Journal of Advanced Nursing, 25*, 1192-1197.

Manning-Walsh, J., Wagenfield-Heintz, E., Asmus, A., Chambers, M., Reed, W., & Wylie, J. (2004). Relationship-Centered Care: The Expanding Cup Model. *International Journal for Human Caring, 8*(2), 26-31.

McCrea, H. & Crute, V. (1991). Midwife/client relationship: Midwives' perspectives. *Midwifery, 7,* 183-192.

Norris, M.K. (1994). Of tea, scones, and British birthing: An American grandmother's observation. *The Journal of Perinatal Education, 3*(1), 1-6.

Ockenden, J. (2000). After the birth is over…rest and support for new mothers. *The practising midwife, 3*(11), 10-13.

Olsson, P. & Jansson, L. (2001). Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations. *Scandinavian Journal of Caring Sciences, 15,* 113-122.

Page, L. (2003). One-to-One midwifery: Restoring the "with Woman" Relationship in Midwifery. *Journal of Midwifery & Women's Health, 48*(2), 119-125.

Rees, C. (1997). *An Introduction to Research for Midwives.* Books for Midwives Press: Cheshire, England.

Rogers, C., Bloomfield, L., & Townsend, J. (2003). A qualitative study exploring midwives perceptions and views of extending their role to the examination of the newborn family. *Midwifery, 19*, 55-62.

Singh, D. (2001). Postnatal care in the month after birth. *The practising Midwife, 4*(5), 22-25.

Spurgeon, P., Hicks, C., & Barwell, F. (2001). Antenatal, delivery, and postnatal comparisons of maternal satisfaction with two pilot *Changing Childbirth* schemes compared with a traditional role model of care. *Midwifery, 17*, 123-132.

Stamp, G.E. & Crowther, C.A. (1994). Women's views of their postnatal care by midwives at an Adelaide women's hospital. *Midwifery, 10*(3), 148-156.

Story, D., Frederick, A., Hoornstra, L., Krob, A., Mayer, H., Meyers, S., & Smola, B. (1996). American Nursing Students in an English maternity setting. *Journal of Nursing Education, 35*(7), 329-331.

Thompson, J.E., Oakley, D., Burke, M., Jay, S., & Conklin, M. (1989). Theory building in Nurse-Midwifery: the care process. *Journal of Nurse-Midwifery, 34*(3), 120-130.

Tinkler, A. & Quinney, D. (1998). Team midwifery: the influence of the midwife-woman relationship on women's experiences and perceptions of maternity care. *Journal of Advanced Nursing, 28*(1), 30-35.

Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery, 15*(3), 165-176.

Appendix A

Observation Record

ID#__________

Type of Care- Standard/ One-to-One

Visit start time____________

Visit end time_____________

Type of setting- Hospital/ Birth Center/ Home

Appendix B
Observation Record

ID#__________

Type of Care- Standard/ One-to-One

Themes to observe—

Professionalism vs. Friendship
-maintaining boundaries, not creating dependency
-is there an emotional involvement?
-do midwives share personal information?
-are the visits focused on the mother, not the midwife?

Intimacy
-knowing and sensing the other within boundaries
-commitment shown by timely meetings, answering all questions
- level of formality i.e. how subjects address each other, use of touch

Communication
-listening
-sharing information (what type - focused on the mother, personal stories, etc.)

Sense of Security
-women being able to contact their midwife whenever needed
-women trust the midwife with what they disclose and don't feel hindered to share

Respect
-understanding of woman and family
-maintain respectful environment
-are there distractions? i.e. dogs, kids, father
-is the concept of space respected and is touch observed?
-positive encouragement, validation of woman's efforts

Facilitating/Enabling vs. Dependency
-acknowledging that the mother is the one doing the work; not taking control
-does midwife dominate the visit or allow the mother to be in control?
-being a leader, but not making decisions for the mother
-acknowledge the woman as an expert in pregnancy and childbirth

Grief at end of relationship
-how do midwives prevent this and how do they say goodbye?

Reciprocity
-exchanging ideas, achieving goals, compromising

-mutual trust, honesty, and sincerity
-shared control and decision making

Appendix C

Semi-structured interview questions

I. Closed questions

1. How many years have you practiced as a midwife?

2. Do you practice the one-to-one midwifery model of care or traditional care, and how long have you been practicing this model? If you have had experience practicing both models of care, how much time have you spent working in each model?

3. (For hospital postnatal visits)---
What is the average time you spend with a mother and family at a postnatal visit?

II. Open questions

1. From your experience, what do you believe to be the most important characteristics of the midwife-mother relationship?

2. What facilitates a positive midwife-mother relationship in midwifery care?

3. What about standard midwifery care do you believe enhances the midwife-mother relationship and how?

4. (If one-to-one midwife)- What about one-to-one midwifery care do you believe enhances the midwife-mother relationship and how?

5. What barriers do you perceive with your clients in forming and/or maintaining positive relationships?

6. Do you feel that your relationships with mothers have ever created dependency for the woman or yourself? If so, please describe how or why this happened.

7. How or what do you do to prepare the mother for terminating her contact with you postnatally?

8. How or what do you do to prepare yourself for ending the relationship with the postnatal woman?

9. Is there anything else about the model of care you use as a midwife or the process for terminating your relationships with women postnatally that you would like to share?

Appendix D

Informed Consent

Western Michigan University
Bronson School of Nursing
Principal Investigator: Mary Ann Stark, Ph.D., RNC
Student Investigator: Danielle Matthys, nursing student

You have been invited to participate in a midwifery research study. The title of this study is "Exploring the relationship between U.K. midwives and first time mothers receiving one-to-one vs. standard midwifery care during the postnatal period." This research is intended to study how midwives interact with mothers under the different models of care. This project is Danielle Matthys' honors thesis project.

You will be invited to allow the researcher to observe you giving postnatal care for **an entire day**. Following this observation, you will be asked to participate in an interview with the researcher in a quiet, private place. The interview consists of open and closed questions and will not last for more than one hour. Upon permission, the interview will be tape recorded in order to clarify notes at a later date if needed. You do not have to answer any question that you are uncomfortable answering and can request that the student researcher not observe your interactions with a particular patient. **If any identifiable information should arise, the student researcher will delete it or disguise it.**

If you are part of this study, there are no major risks anticipated. The participants will have no alterations in their midwifery care related to the research. The researcher will be present in the room during postnatal care. Some women may feel uncomfortable having an observer present during care. The researcher is a student nurse who has been present for other postnatal care. She will sit or stand in the room in a place that is out of your way. If you find the presence of the researcher uncomfortable, you can notify the researcher and she will change her position in the room so that she can observe you from another location in the room. There is a time inconvenience for midwives who participate in the interview process, which will last for no more than one hour.

One way in which you may benefit from this activity is being professionally satisfied by participating in a research study. Through the study, knowledge will be gained on the inherent factors that make a relationship positive between the midwife and the mother and to see if the midwives who offer different models of care play a role in relationship factors. One area that is under researched will be paid close attention to, namely how midwives end the relationship. This knowledge may improve practice for midwives.

All of the information collected from you is confidential to the extent permitted by applicable laws and regulations. That means that your name or other identifying information will not appear on any papers on which this information is recorded. The forms will all be coded, and Danielle Matthys will keep a separate master list with the

names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed. All other forms will be retained for at least three years in a locked file in the principal investigator's office. Tapes from recorded interviews will be destroyed upon returning to the United States after an accuracy check is completed among the committee. If the results of this study are published, or presented at scientific meetings, you will not be identified in any way.

Taking part in the research study is voluntary. You may refuse to participate or quit at any time during the study without prejudice or penalty. If you decide to withdraw, you may do so without giving a reason. The researcher may ask for your reason. If you decide to share the reason, the researcher will record this reason as part of the research. If you have any questions or concerns about this study, you may contact either Danielle Matthys at 269-718-9130 or electronically at d2matthy@wmich.edu or Mary Ann Stark, Ph.D., RNC at 269-387-8234 or mary.stark@wmich.edu . You may also contact the chair of Human Subjects Institutional Review Board at 269-387-8293 or the vice president for research at 269-387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

Your signature below indicates that you have read and/or had explained to you the purpose and requirements of the study and that you agree to participate.

______________________________ ____________

Signature Date

Consent obtained by: ____________ ____________

Initials of researcher Date

____

Permission to tape interview

Appendix E

Email recruitment script

Hello. My name is Danielle Matthys. I am a nursing student from Western Michigan University who will be in London from July 28 until August 11 conducting research for my undergraduate honors thesis titled "An Exploratory Study of the Relationship between U.K. Midwives and First Time Mothers Receiving One-to-One vs. Standard Midwifery Care During the Postnatal Period." I originally contacted Dame Karlene Davis, General Secretary of the Royal College of Midwives with the assistance of my thesis mentor, Dr. Joyce Thompson. Dame Karlene, in turn, directed me to Sue Jacob, Student Services Advisor of the Royal College of Midwives. I have been corresponding with Sue and she has provided me with your name or institution as a potential candidate for my research project. The purpose of this letter is to recruit you to be a subject in my research project.

Over the past six months, I have extensively reviewed the literature on both the One-to-One model and traditional model of midwifery care. The purpose of my thesis project is to gain knowledge on relationship factors between midwives and mothers in the postnatal period under both models of care. I would like to have a variety of settings, including home visits in the city and rural areas as well as postnatal time in the hospital setting. Should you agree to be a subject in my study, I will unobtrusively observe you interact with mothers during postnatal visits. The mothers at no time are subjects in the study. After observation, which will take place for the day, I will subsequently conduct a semi-structured interview with your permission. The interview consists of three closed questions and nine open questions and will take no more than one hour. After the interview, which will be tape recorded with your permission, you will have the opportunity to review my handwritten notes and make any changes you see fit. At no time will you or the mothers be identified in the data collected. I am currently receiving approval from the Human Subjects Institutional Review Board for my project.

If the project sounds of interest to you, please respond to me through email so that I can arrange a day to meet with you and observe you providing care to mothers in the postnatal period. Any day from July 29-August 10 is feasible. Please indicate if you practice One-to-One or traditional midwifery care. I am leaving for London for a nursing class through Michigan State University on July 3 and would like to have appointments set before leaving the country.

Thank you for your time,

Danielle Matthys

Description of the process for initial visit with midwives

1) **Basic introduction of self and study to midwife**
2) **Provide informed consent form**

3) **Review and answer questions**
4) **If midwife agrees to sign, she can sign and keep a copy**
5) **Observe midwife for day**
    a. **Gain oral permission from mothers to observe their interactions with midwife**
        i. **Repeat Appendix F to mothers**
6) **Interview midwife after observation**
    a. **Tape record if consent obtained**
7) **Allow midwife to review handwritten interview notes**

Appendix F

Script to gain permission from mothers

Hello. My name is Danielle Matthys and I am a nursing student from Western Michigan University. I am in London conducting research for my undergraduate honors thesis project. I will be unobtrusively observing how your midwife provides care to you during your postnatal visit and taking notes. Your midwife is the subject and whom I will be collecting data on. At no time will I be collecting data on you or your infant or consider you subjects in my project. In no way will you be identified in the data I collect.

I will only observe your visit with your midwife with your permission. If at any time during the visit you feel uncomfortable with my presence, please let me know and data collection on your midwife will cease and I will leave the room.

Is it okay with you for me to observe your midwife?