Is a midwife's continuous presence during childbirth a matter of course? Midwives' experiences and thoughts about factors that may influence their continuous support of women during labour

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ABSTRACT

Objective: to gain an understanding about midwives' experiences of providing a continuous supportive presence in the delivery room during childbirth, and to learn about factors that may affect this continuous support.

Design/setting: qualitative study at a maternity unit in Norway, where about 4000 births take place each year. In-depth interviews were conducted with ten midwives working in two different maternity wards. The qualitative data were analysed using systematic text condensation.

Findings: the analysis generated three main themes: relational competence, the midwife's ideology, the culture and philosophy of the maternity unit. The midwives identified being mentally present and actively developing mutual trust with the woman in labour as two very important factors for building a relationship with her. They suggested that the midwife's first encounter with the woman is a key opportunity for establishing rapport during labour. Successfully providing a continuous presence during labour fostered the midwives' perception of themselves as a 'good midwife'; this was considered a feature of holistic care and health promotion. The workload in the unit sometimes made it difficult for them to provide a continuous presence in the delivery room. The midwives experienced feelings of inadequacy when they felt that they had too little time available for the woman in labour.

Key conclusions: midwives' skill in building a relationship with the woman in labour combined with their values and understanding of the midwifery profession are important factors influencing their decision to provide a continuous presence during childbirth. If it is policy that maternity units should provide continuous support to women in labour, managers should ensure that it is actually provided.

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Introduction

Historically, women have always been cared for and supported during labour. As births have moved from home to hospitals, continuous support for the woman in labour appears to have been an exception rather than the rule (Hodnett et al., 2011). However, most women in Norway nowadays give birth in large maternity units, with care that is more differentiated and fragmented than in the community midwifery service they have replaced. The community midwives of the early 1900s practised holistic antenatal, intrapartum and postnatal care (Blåka, 2002). Today's centralisation and fragmentation may dehumanise the woman's birth experience. Modern maternity units expose women to the institution's procedures and technology, the imposition of which may have adverse effects, even on the progress of birth (Hodnett et al., 2011).

Continuous presence during labour enables the midwife to provide emotional support, information and guidance. This may reduce the need for intervention during birth and promote a normal birth, as well as increase the woman's sense of control and coping (Hodnett et al., 2011). Women with access to the continuous presence of a midwife during labour are more likely to give birth spontaneously. The risk of instrumental delivery, caesarean section, and continuous fetal monitoring is reduced, and the babies have higher Apgar scores. The midwife's presence also affects the woman's choice of pain relief (Nelson, 2003; Halldorsdottir and Karlsdottir, 2011; Hodnett et al., 2011; Howarth et al., 2011). The midwife's continuous presence is important for the woman's birth experience. Her presence promotes maternal attachment to the child, as well as the physical...
and mental well-being of the new family (Carlton et al., 2005; Rijnders et al., 2008; Howarth et al., 2011).

Women greatly appreciate the midwife’s continuous support during labour (Berg et al., 1996; Callister et al., 2010; Howarth et al., 2011), Lundgren et al. (2009) and Howarth et al. (2011) argue that the relationship built with the woman and the atmosphere created by the midwife’s presence is the key to a positive birth experience. To reduce the risk of post-traumatic stress and maximise positive psychological outcomes for women in the postnatal period, the midwife’s continuous presence during labour is more important than the woman’s experience of being in control during labour (Ford and Ayers, 2011). The quality of the relationship between the midwife and the woman in labour is an important factor in the quality of midwifery care. However, it is frequently underestimated, and is often not even mentioned in discussions of key issues in maternity care (Downe, 2008). The relationship between the midwife and the woman draws together all of the aspects of care. All guidelines, procedures, information and policy are of limited value if the relationship between the woman and the midwife is not good enough (Hunter et al., 2008).

In 2007, the National Institute for Health and Clinical Excellence in the UK published evidence-based guidance for the care of healthy women and their babies during birth. All conclusions were based on results from research. The guidelines emphasised that all women should have one-to-one care during birth. Women in labour should not be left alone, except for short periods or if it is their own preference (NICE, 2007). In Norway, this means one-to-one midwifery care, because it is the midwives’ responsibility to provide care during normal, uncomplicated births. The NICE guidance is partly based on the guidance and principles of maternity care developed earlier by the World Health Organisation (WHO, 1996). In several documents, WHO emphasises that a woman in labour should never be abandoned; the midwife should be continuously present to provide the best possible support. Proposals and reports from the Norwegian Directorate of Health (2010) indicate the need to comply with these provisions, but they have still not been included in official Norwegian guidance documentation.

The aim of this study was to gain an understanding about midwives’ experiences of providing a continuous supportive presence in the delivery room during childbirth, and to learn about factors that may affect this continuous support. Offering continuous presence and labour support include continuous availability to the woman and her partner, giving as needed.

Method

Data collection

A qualitative approach was chosen for data collection, and the data presented are from in-depth interviews. All the midwives at a large maternity unit in Norway, with around 4000 births each year, received an email requesting their participation in the study. At maternity units in Norway, midwives, as opposed to other healthcare professionals, are responsible for the delivery of care in normal births. The wards vary in size and amounts of births per year, but in general midwives are often responsible for more than one woman in labour at any given time. Ten midwives aged 37–56 working in full or part time at two different maternity wards volunteered to take part. All participants had spent most of their career working in a maternity unit, and had 1–30 years of midwifery experience. They covered day, evening and night shifts. The participants were given written and oral information about the aim of the study, and were assured that all data would be treated confidentially. They provided written informed consent to participate in the study. The project was approved by the Regional Research Ethics Committee. The interviews were conducted either at the University College or at the maternity unit, depending on which was the most convenient for the midwives. Each interview lasted 45–60 minutes. An interview guide with open-ended questions was prepared in advance (Table 1). The questions derived from a literature review on the topic and from professional knowledge and experience. The guide was used to keep the conversation within the chosen subject, rather than for asking specific questions (Malterud, 2011). The assembled data were rich in content, as all the midwives spoke freely about the topics and provided detailed descriptions of their experiences of clinical practice.

Data analysis

The interviews were observed, tape-recorded and transcribed verbatim. All three authors carefully analysed the qualitative data and applied systematic text condensation. This method, developed by Malterud (1993), is a modified version of Giorgi’s (1985) phenomenological analysis. The method is well suited for descriptive analysis of described phenomena to develop new descriptions and concepts. The purpose of the phenomenological analysis is to develop knowledge of the informants’ experiences within a particular field. The researchers look for ‘essences’, the essential characteristics of the phenomena. The analysis followed a four-step process (Malterud, 2011). First, all the interviews were read to obtain an overall impression; the wholeness of the text was more important than the details. The researchers looked for themes representing the midwives’ thoughts and experiences of providing a continuous presence and support during childbirth. To avoid bias, the researchers tried to suspend or ‘bracket’ their own assumptions in their encounter with the data. They made active efforts to suspend preconceptions and the theoretical reference framework. In the second step, text units that might illuminate the focus of the study were identified. The material was systematically reviewed, line by line, to identify units of meaning. These units were coded by identifying and classifying all the meaningful units in the text related to the topics noted in the first step of the analysis. In the third step, the content was condensed, abstracted and summarised for each coded group. In the fourth step, the experiences and thoughts of the midwives were summarised in re-contextualised versions providing the basis for new descriptions and concepts.

Success in systematic text condensation depends on the researchers’ ability to bracket preconceptions. When researchers impose earlier knowledge and experiences upon the analysis, its validity is compromised (Strandmark, 2004). During the whole analysis process, the interpretations and themes were intricately discussed by the three authors.

Findings

The findings from the analysis are presented below. They cover three main themes: relational competence; the midwife’s

| Table 1 |
| What do you think about the midwife’s continuous presence in the delivery room during childbirth? |

- What do you think about challenges you face at work?
- What about personal challenges?
- Why do you think continuous presence is important/not important?
- What do you think might be the advantages/disadvantages associated with the continuous presence of the midwife for the mother/father and the newborn child?
Relational competence

The first meeting

The informants highlighted the importance of spending enough time at the first meeting with the expectant mother, to build a relationship and to provide confidence to the woman and her partner. A trusting relationship can be built by using all your senses to find out who the woman is, and what she needs. This is a time-consuming process. The midwives emphasised that exchanging information creates a level of predictability and shared confidence, contributing to trust between the woman and the midwife. It was important to allow enough time for the pregnant woman to become acquainted with the midwife, to feel reassured that the midwife had enough time for the woman, and for the midwife to learn about the woman’s needs and expectations. The informants felt that it was essential to obtain permission from the colleagues to be present as much as possible during the first meeting. They also emphasised the importance of establishing a good relationship with the woman’s partner during the first meeting, so that the partner could relax, confident that the midwife would be present for both of them:

So I’m sitting there until I feel we have all settled, and I know that they feel confident by the time that I walk out of that room (Midwife Hanna)

Good information and continuous presence early in labour forms the basis for further relationship building. If things go wrong at the beginning, you have to work incredibly hard to rectify the situation and to gain trust again (Midwife Sigrid)

Being mentally present and mutual trust

The informants highlighted the importance of being mentally present for the woman in the delivery room. They believed that mental presence and attentiveness provided confidence, even if they could only be present for five minutes at a time. Quality of care meant more than quantity. The midwives pointed out that a calm atmosphere in the delivery room helped to protect the couple from the busyness elsewhere in the maternity ward; it also enabled them to feel that the midwife had the time to provide good care. The midwife’s physical presence did not help if her attention was focused on events in another delivery room:

One should be there full of oxytocin, not full of adrenaline (Midwife Randi)

The informants highlighted the importance of guiding the woman in labour to engage in coping strategies. They expressed that being supportive involves being positive, and showing that you have faith in the woman’s resources. This enables the woman to experience empowerment and confidence, which is less likely to happen if the midwife is absent:

It’s important to make myself redundant, so that they feel a sense of coping. I want them to think: ‘It was not the midwife who did it, she helped me, but we were the ones who made it!’ That is my job! (Midwife Helena)

The informants emphasised that if a midwife is to achieve trust and a good relationship with the woman in labour, the midwife must have confidence in herself and in her professional expertise. This is not necessarily a function of how long one has been qualified:

It lies in the personality. Not everyone is good at building relationships. Me neither, but I have invested in it, and have become much better over the years. Successful encounters are those when you feel that the relationship has been so good that you almost feel sad to go home from work (Midwife Kari)

The midwives believed that their continuous presence gave them a better overview of the progress of labour, the condition of the fetus and the prospects of a normal birth. They pointed out that if they did not have time to be fully present, and the relationship building failed, they became hesitant and more likely to intervene in the birth process. They affirmed that mutual empowerment of the woman and the midwife was important:

Presence, it’s actually the continuity. Being with them is good for the couple and it’s good for us. We get to know what they think and what they may need. Then we get wiser, all the time. (Midwife Helena)

The midwife’s ideology

To be a good midwife

The informants noted that continuous presence and support sometimes simply involved being there, spending time with the couple while checking the baby’s condition and observing the progress of labour. They believed this was the only proper way of working; it was not acceptable just to stand in the door and check verbally that everything was all right. Continuous presence enabled them to function as a good midwife:

It’s important that the women have enough confidence to enter the glass bubble and let me stand outside. I just look inside. They know I’m there, but I’m not important. I’m just there in a way and provide reassurance that the glass bubble is right (Midwife Helena)

The informants believed that the more one knew about the effect of continuous presence, the more committed one was in making the woman safe and confident during birth. The midwife contributes to a successful labour through her presence, rather than through automatically intervening. They suggested that the midwife’s continuous presence might increase the likelihood of a natural birth, without interventions such as epidural analgesia and oxytocin—and the spiral of escalating intervention that these can lead to:

Continuous presence is one of the most important things, that’s for sure! It is our job—being continuous present and being available. The first commandment, that’s it! (Midwife Hanna)

The informants explained that midwives’ ideology and understanding of the nature of the midwifery profession affect how they utilise the opportunity to provide continuous support. They recognised that individual midwives worked in different ways: some are more impatient and resort to interventions more often, whereas others believe that confidence and continuous support from the midwife are the most important factors for women during childbirth. It was suggested that not only midwives might be impatient, but also some of the pregnant women. Some wanted the birth to take place on a certain day, at a certain time, whereas others believe that confidence and continuous support is one of the most important factors (Midwife Eli)
Holistic care in a health-promoting perspective

The informants emphasised that when midwives were not present, they missed valuable information that might contribute to a normal birth. They suggested that the continuous presence of a midwife might prevent the use of oxytocin, epidural analgesia, delayed progress in labour, and surgical interventions. Midwives who are continuously present can observe the woman carefully during labour, without resorting to unnecessary technology and numerous vaginal examinations:

When an epidural is so easily available, it is easier for women to give up. If you haven't been sufficiently supportive to the woman in advance, it's often difficult to make her think differently after she has asked for epidural. It's kind of too late (Midwife Hanna)

The informants were all concerned that the midwife's continuous presence should be provided on the couple's own terms and that, to provide individualised care, it must be possible to offer the time that the woman needs. They identified that the midwife is responsible for the birth, and so should have an overview of the process:

Sometimes I meet women who know how they want it to be, and who tell me with their body language that you should just be far away. 'You should just stand over there, because I'll do it myself' – and that's just fantastic! That is more than enough, because she knows you are there if she needs you. At other times I might hold her tightly every time she has a contraction, and this may also be appropriate. So it's important to be aware of this, but to sense it you need, in a way, enough time to see it (Midwife Charlotte)

The informants believed that the continuous presence of the midwife was important for the woman's experience of confidence and coping during birth and for her birth experience. Failing to provide continuous support might lead to an experience of being alone and unsafe, which might result in a traumatic birth experience. The informants noted that continuous presence of the midwife might diminish the woman's fear of giving birth, and consequently reduce the incidence of requests for a caesarean section in the next pregnancy. They pointed out that the mother's positive experience of birth can be nurtured even if interventions are required. They argued that the reassuring presence of the midwife could contribute to the new mother's mental well-being after the birth, her bonding with the newborn child, and the family's future health:

What we do has a very significant impact. It's like an octopus with many arms. We sort of embrace quite a number of aspects of becoming a mother and a father. This is a transition to something good, but it may also go really bad if the midwives don't have time (Midwife Hanna)

The culture and philosophy of the maternity unit

Accepting the value of being continuous present

The informants called for leaders, obstetricians and midwives who could be seen as champions of the topic, and who could focus on the importance of continuous presence and support. They stressed that it was not enough just to argue; this should also be a theme reflecting the ward's culture and philosophy. They asserted that everyone should be more conscious of the important qualities in midwifery care. However, they believed that midwives' continuous presence during labour was not valued; it is difficult to measure and is not a procedure that is easy to tick off and to be paid for. The informants highlighted the importance of feeling that they were permitted to be continuously present for the woman when necessary. This required close collaboration between colleagues and an understanding of each other's different ways of working. Close collaboration should be facilitated to utilise each other's strengths within a team. The informants said that there were different levels of understanding and acceptance of a midwife's continuous presence during childbirth and major differences in how individual midwives worked. Some were continuously present throughout labour, others less so. The informants mentioned that they sometimes attracted snide comments when they tried to spend extended time with a woman in labour. Some said that sometimes they used the bathtub as an excuse, if the ward was busy, as it was not permissible to leave a woman alone in the bath:

I said to my colleague: You cannot stay in there, because we don't have time! My colleague answered: But my woman demands it and needs it! I answered: But, so does my woman! Since you do it, I cannot. I should be in there at least fifteen minutes before she starts pushing, but I cannot do even that because you have been gone for two hours. Which means that you demand that I should provide poorer care because you want to offer what you feel is right. This is a common theme in our ward, and it's very disappointing (Midwife Helena)

Experience of inadequacy

The informants spoke about the challenges associated with inadequate staffing levels, leaving midwives on duty with responsibility for several women at the same time. The midwives became frustrated and felt inadequate because they had insufficient time to build a relationship with the couple. The informants recognised the need for their continuous presence, but acknowledged that they did not always have time to provide that level of care:

WHO emphasises that this should be possible. Someone should be there in the active stages of labour at least. Therefore, you are sort of a little upset when you notice that it goes the other way. Sometimes I am wondering if it's worth it, in a way. If there is any point working as a midwife, when you feel that everything works against you (Midwife Eli)

My frustration is sometimes misunderstood. They believe I am complaining about busyness, but what I actually mean is that I have not had sufficient time to spend with each individual woman. It's very important to feel that you have done a good job, and you can see that the woman has coped with her birth and is satisfied (Midwife Kari)

The informants also said that when the ward was busy, midwives sometimes resorted to epidural analgesia rather than extra support to the woman, and to the use of continuous fetal monitoring that they could observe from outside the room. It was even said that, due to staff reductions and a high incidence of complicated deliveries, sometimes mothers expecting a normal birth were left waiting in the hallway. They could barely enter the ward, they were given almost no space, and they came last in the queue for attention. Because of this, midwives expressed concern about mothers' fear of birth and the likelihood that they would request a caesarean section in their next pregnancy:

You go back, and you see a CTG you cannot interpret. What does this mean? Is it the mother's pulse? Or is it the child's heartbeat? Have no idea, you know, because you haven't been there. It's rare, but it happens. You cannot just put on a CTG and leave the room, you have to be there (Midwife Ann)

The informants agreed that having more midwives on duty would make it possible for them to provide more continuous presence and support. However, even then, some midwives would not manage to provide a continuous presence throughout
each shift. This was due to the extreme emotions and situations that unfold in a delivery room. The midwives said that it was important to protect yourself, if you hoped to be able to work as a midwife for many years. They said that it was very demanding to provide continuous support to individual mothers in a maternity unit:

You have extremely sad experiences happening in one room, and extremely gratifying ones in the other room and you are standing there in the middle. You reset yourself in the corridor. It’s really hard (Midwife Helena)

It is challenging when the woman has a fear of birth. You give so much of yourself, but sometimes you are unsuccessful. Other times it may be that the chemistry does not match (Midwife Sigrid)

The midwives highlighted the importance of providing continuous support when they actually had time to do so. Some did not utilise this opportunity on shifts that allowed for it, because of the busy-ness mentality on the ward, and the expectation that you should always do other types of work in between:

I think it’s important that I am there as much as possible, and I have a guilty conscience when I go in and out. It has become normal practice to have several simultaneous tasks. When that happens, I don’t feel calm; I feel there is something out there that has not been clarified or that I have to do (Midwife Mari)

Discussion

The midwives in this study said that they believed their continuous presence and support during the process of labour was of great importance for the woman and her partner, the family’s future well-being, and the midwife’s sense of being able to work in harmony with her ideology. International ethical guidance for midwives is based on the principle of working with the woman during childbirth (ICM, 2008). Yet the professional standards and values of some midwives are at variance with these guidelines. According to Haldorsdottir and Karlsdottir (2011) and Russell (2007), midwives often work with clinicians who have a different ideology, which can be very challenging for the midwives. Bluff and Holloway (2008) suggest that in some hospitals there is a risk that midwives are expected to support the demands and values of the clinician rather than those of the woman in labour. These situations provide a bad example for student midwives, because they foster a midwifery culture that is inconsistent with ethical guidance, and where the women’s needs are not met. Waldenström (1998) has argued that the values and attitudes of midwives are probably the most important factors affecting women’s satisfaction with midwifery care.

The informants in this study had a perception of providing inadequate care, especially during busy shifts, and because of different ideologies among professionals in the ward. Some respondents had begun to question the point of their work as a midwife. Hunter (2004) proposes that when midwives are not utilised this opportunity on shifts that allowed for it, because of the busy-ness mentality on the ward, and the expectation that you should always do other types of work in between:

I think it’s important that I am there as much as possible, and I have a guilty conscience when I go in and out. It has become normal practice to have several simultaneous tasks. When that happens, I don’t feel calm; I feel there is something out there that has not been clarified or that I have to do (Midwife Mari)

The informants believed that the continuous presence of a midwife during labour promotes a normal birth. It also promotes a positive birth experience, even if the birth suddenly becomes complicated. They emphasised the importance of adjusting to the individual women and their varying needs for support, to promote coping. Haldorsdottir and Karlsdottir (2011) propose that the essence of excellent care is the desire to promote the long-term happiness of others. In midwifery, this means that the care must be adapted to each individual, and the dignity of the woman giving birth must be maintained. Callister et al. (2010) found that women believed that the midwife’s role was essentially to promote a positive birth experience. Individualised care and the midwife’s support during the birth were important. Thomson and Downe (2010) explain that the relationships that are built during birth and the quality of care provided are crucial factors for a good birth experience. They emphasise that support during birth is equally important for first-time mothers and for women who had endured previous traumatic birth experiences. Positive, continuous support may alleviate earlier traumatic birth experiences.

Our informants believed that being mentally present and calm was especially valuable, and that the couple should be shielded from the busy-ness elsewhere in the ward. This was important to create mutual trust and to provide a good birth experience, which might influence the family’s future well-being. Rijnders et al. (2008) found that a stressful working situation affects women in labour; the risk of a negative birth experience is greater if they feel that the midwife is in a hurry. A traumatic birth experience may have a major impact on the woman’s sense of identity (Thomson and Downe, 2010). Childbirth is a crucial turning point, and the birth experience can affect whether a woman considers herself a competent mother. A negative experience may influence a mother’s interaction with her newborn baby. The woman’s relationship with the midwife is of great value for the woman’s birth experience; if this relationship is inadequate, the woman may experience vulnerability and fear (Howarth et al., 2011).

The informants emphasised the importance of having time to create trusting relationships. They believed that the first meeting with the expectant mother and her partner was crucial, forming the basis for further relationship building. This reflected the informants’ wish to be ‘a good midwife’. Chairman (2006) emphasises that the midwife–woman relationship is a key aspect of successful midwifery. This relationship involves trust, shared control and responsibility, and shared meaning through mutual understanding. Spurkeland (2005) describes how it is possible to intuitively feel confidence or lack of confidence as a movement towards warmth or coldness in the first meeting. Nicholls and Webb (2006) highlight that being a good midwife, involves having good communication skills to build relationships. A good midwife can see a woman’s individual needs, and take the actions necessary to fulfil them. Through continuous presence and support, the extent of a woman’s empowerment will be increased.
The informants said that midwives need a basic trust in themselves as midwives, to be able to build a relationship with the woman and to provide individualised care. Raknes and Hansen (2006) explain that relational competence is about understanding and interacting appropriately with the individuals one encounters in a professional context. A midwife with relational competence communicates in a way that the woman understands, with the intention of strengthening the woman’s ability to believe in herself. Ólafsdóttir (2006) finds that when midwives are experiencing quality in their relationship with the woman in labour, their job is meaningful and can lead to personal growth and new knowledge.

The midwives expressed a sense of inadequacy due to the perception of not having sufficient time to build relationships. They said that this was not considered important since it could not be measured or coded so that the ward was paid for it. Hunter et al. (2008) point out that the relationship and the midwife's presence are the invisible threads that hold everything together. In Norway, continuous presence and support by midwives is difficult to attain, partly because of centralisation of maternity care into large units, where the medical model is dominant. The smaller midwife-led units are being closed down; it is argued that they are not very efficient and lack professional expertise. In contrast, Rijnders et al. (2008) maintain that giving birth in a large hospital increases the risk of a negative birth experience.

The midwives in this study explained that on busy shifts, as a substitute for their continuous presence in the delivery room, they sometimes use continuous fetal monitoring equipment to observe the condition of the fetus, although this can lead to a false sense of security. They thought that technology should be used as a tool rather than to compensate for the midwife's absence. Carlton et al. (2005) highlight that the importance of continuous presence is often underestimated, and cannot be overemphasised. The advantages of one-to-one care should be evaluated, but it is often assumed that such care is more expensive than, for example, the use of continuous fetal monitoring.

Good midwives are available to the women in labour, and show kindness and compassion. This element may be missing when women receive care in a medically-oriented rather than a midwifery-oriented system (Nicholls and Webb, 2006). Autonomous midwives spend more time with the woman in the delivery room (Russell, 2007). Insecure midwives may rely on technology because they do not have confidence in their own skills and observations (Gagnon, 2011). Technology can create a barrier between the midwife and the woman in labour; even though technology is part of the midwife’s toolkit, it has to be administered properly (Blåka, 2002). Continuous fetal monitoring should not be used in normal labour, as it leads to a higher incidence of interventions and caesarean sections. Costs related to interventions should be taken into account when considering the price of one-on-one care (WHO, 1996). Hodnett et al. (2011) suggest that continuous presence of a midwife is likely to reduce the rate of caesarean section and operative vaginal deliveries as well as the need for pain relief.

We live in a society that is constantly changing. New research, advanced technology and centralisation of health services affect the care provided to women during childbirth. In the organisation of maternity care, it is important to apply evidence-based good practice, including the findings from research about the benefits of the supportive presence of the midwife during labour. If this occurs, midwives will have the opportunity to provide the quality care to which women are entitled.

Limitations

In this study, the thoughts and experiences of a small group of midwives in Norway were explored. It is not suggested that these midwives are representative of all other midwives. It is possible that the midwives who were willing to participate in the study were a self-selected group who wanted greater focus on continuous midwife presence during childbirth. However, the small sample size does not mean that the findings are irrelevant. The midwives gave rich descriptions of their experiences, which provided understanding of some factors that may influence midwives’ continuous presence during childbirth. Larger studies will be necessary to provide a basis for conclusions. Interviewing midwives from smaller maternity wards would be of interest for further research, particularly in relation to the current trend towards centralisation of maternity care in Norway.

Conclusions

This study has provided some insight about factors that midwives believe are important in relation to their continuous presence during childbirth. These midwives regard continuous presence and support as essential, both to provide quality care for the woman in labour and for the longer-term family well-being. The midwife’s ability to build a relationship with the woman and her partner, and her values and understanding of the midwifery profession are important features in the effectiveness of her continuous presence. Regardless of these factors, given that the continuous presence of midwives during labour is acknowledged as a desirable policy objective, managers of maternity units should actively seek to ensure that it is implemented. In the organisation of maternity care, it is essential to apply existing research on this area. This will give midwives the opportunity to engage in best practice, enabling women to receive high-quality midwifery care.

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