**The midwife as an "instrument" of care**
Holly Powell Kennedy
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under investigation, given that breast cancer patients at advanced stages and with larger tumor sizes generally have worse survival rates than patients at earlier stages and with smaller tumor sizes.

Inclusion of birthplace information in research designs can result in the identification of vulnerable subpopulations to be targeted for public health services, and such data can provide etiological insights as well. However, if this increasingly important information is to be useful, hospitals need to adopt policies aimed at improving its collection; the quality and completeness of birthplace data can be improved only at the level of the reporting facilities. ■

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***Note.*** *The views expressed in this brief do not necessarily reflect the views or policies of the US Department of Health and Human Services or the California Department of Health Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the US government or the state of California.*

**Contributors**

S.S. Lin conducted the analysis and took the lead in writing the brief. C.A. Clarke, C.D. O'Malley, and G.M. Le contributed to interpretation of the data and revision of the brief.

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**Human Participant Protection**

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# The Midwife as an "Instrument" of Care

| Holly Powell Kennedy, PhD, CNM

A qualitative study was conducted with midwives from across the United States during 2000–2001 that suggests alternative approaches to caring for women and infants during pregnancy and birth. This study was a follow-up of a Delphi study in which 64 expert midwives and 71 recipients of midwife care sought to achieve consensus on dimensions of exemplary care.[1] (Delphi studies involve the use of a panel of identified experts to come to consensus, by means of an anonymous survey, about a complex problem or issue.) The dimensions identified were as follows: (1) therapeutics (how the midwife decided to use specific therapies in practice), (2) caring (the midwife's relationship with the woman and her family), and (3) profession (how the profession of midwifery was enhanced by exemplary practice).

As a means of corroborating these findings, 11 midwives who took part in the original study were interviewed on videotape providing narratives about their practice. This report presents the results of this follow-up study. The mean age of the sample was 54 years (range: 49–62 years), and the median number of years in practice was 20 (range: 6–29). All of the participants practiced full-scope midwifery, providing both childbearing and gynecologic care. Hospitals served as the birth setting for 64% of the midwives; 18% attended births at homes, and 18% did so in birth centers. Most of the participants (64%) had master's-level educations.

Videotapes were transcribed and analyzed via constant comparative methods used in grounded theory. Findings showed that several processes of care dominated, and these results supported and extended those of the earlier study. For example, many of the midwives used the phrase "the art of doing nothing well" to describe a process of care centered on the midwife's presence with the laboring woman and the creation of an environment supporting pregnancy and birth as normal processes. This process included selective use of interventions based on clinical judgment and the woman's wishes.

The midwives described an intricate, attentive, and even vigilant stance in regard to assessment and guardianship of the birth process. They expressed a belief that, unless proven otherwise, the mother and fetus are almost always physiologically able to complete the process, with the midwife as a present but nondominant force. One specific ap-



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proach included the creation of an environment that was safe and that inspired a sense of normalcy. According to one midwife:

> What I have found that I need to continue to do is [to continue to] articulate how well mom is doing in a really low-intervention process. Otherwise, if I slip and stay silent, things get done [that don't need to be done]. . . . I want everyone in the room to continuously hear that this [maternal and fetal assessment during labor] is normal; the silence, that road, gives residents, interns, nurses the . . . [opportunity] to fill it with their fears and anxiety.

Care was, above all, respectful and the midwife was considered an invited guest, worked with the woman and her family as a partner, and was ready to take charge, but only if necessary:

> I was a guest and I was invited to be an expert, but only if they needed me to be one. . . . I would talk about how, "Here's the circle of safety, and as long as you give me normal [maternal and fetal assessment during labor] within it, my job is to just stay outside the boundaries. When you bump the boundaries, my job is to gently guide you back."

Pregnancy and birth were thought to have important physical and emotional effects. Assisting the woman to achieve her goals during the birth was considered a way of helping her to assimilate a new motherhood role, one that would require strength. In the words of one of the midwives:

> That is to me what I think a midwife should be able to do: to somehow find that part of a woman, whatever that part is—and it can be in many different ways—that enables her to reach that strength and retain that strength.

The midwives were not opposed to technology or interventions in general and, in fact, used them creatively and expediently when needed. Optimal health of the mother and infant was paramount, and sometimes an epidural or an operative delivery was required. However, they noted that the low-technology use of their presence was vitally important and that it became an instrument in the care process. For example:

> The piece [element] that I have found that is most critical to me to reflect midwives, and me as a midwife, is quiet and spaciousness within a very, very busy frenetic environment. So, each time that I present myself to a client, that's where I go. I go to a place of introducing myself, sitting down and asking the client what she needs. Just giving them the opportunity to know that this is their special time. What I have seen happen is that all of a sudden there is this sigh of "Okay, everything is fine, nothing is going to happen to me, I'm safe and I'm being attended to."

A model of care in which providers themselves are the "instrument" of care seems counter to the growing emphasis on technology in the treatment of women during pregnancy. Working to create an environment of calm, trusting in the normal birth process, and being present during labor may appear to be "nothing" or inconsequential, but in reality it is likely to be very significant. The United States spends more per capita than any other industrialized nation on health care, yet the country ranks only 27th in terms of infant mortality.[2] Much of that expenditure is aimed toward technological advances rather than personalized care during pregnancy and birth. In fact, the majority of countries with the best birth outcomes have midwives as frontline providers of maternity services.[3]

While midwifery has been shown to produce excellent outcomes,[4–7] and while the practice has grown markedly,[8] it is still seen as an alternative maternity care model in the United States. To date, there has been little research on how midwives achieve their remarkable results, although a recent review indicated that birth outcomes are improved when the mother has a supportive caregiver present during labor.[9]

The findings of this qualitative study suggest that midwives' processes of caring for women may have significant health effects. Future investigation is essential to identify these processes more definitively and to correlate the midwifery model of care with both short- and long-term maternal, infant, and women's-health outcomes. ■


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### Human Participant Protection

This research was approved by the institutional review board of the University of Rhode Island, and written informed consent was obtained from all participants.

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