

Being With Woman: A Guiding Concept for the Care of Laboring Women

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Objective: To review the literature concerning the midwifery concept of *being with woman* and the related nursing concepts of presence and social support during childbirth.

Data Sources: Literature in the English language from 1985 through 2000, using MEDLINE and CINAHL.

Data Extraction: Discussion of articles from relevant journals and textbooks were included. Pertinent older sources, which enhanced the understanding of the concepts, were reviewed.

Data Synthesis: *Being with woman* is defined as the provision of emotional, physical, spiritual, and psychological presence/support by the caregiver as desired by the laboring woman. Ample evidence exists for including being with woman as a central concept of the model of care for women in labor. The qualitative review indicates that women value and desire the attributes of the concept during childbirth. The qualitative and quantitative literature demonstrate beneficial physiological and psychological outcomes for women who experience being with woman.

Conclusions: Obstetric units would be wise to incorporate the being with woman model of care as routine policy for the care of laboring women by midwives and nurses. Being with woman provides psychological and physiological benefits for women, client satisfaction, and potential cost savings. *JOGNN*, 31, 650–657; 2002. DOI: 10.1177/0884217502239213

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The word *midwife* is derived from old English and literally means *with woman*. The purpose of this article is to analyze the concept *being with woman* and its implications for midwifery and nursing care. Being with woman is defined as the provision of emotional, physical, spiritual, and psychological presence and support by the caregiver as desired by the laboring woman. Because of the uniqueness of the concept to midwifery, two closely related concepts from the midwifery and nursing literature—*presence* and *social support*—will be reviewed. Although the term *intrapartum* nurse is not derived from being with woman, in the hospital the nurse is the main caregiver for the laboring woman who is not attended by a midwife.

A second reason for analysis is to determine if this age-old hallmark of midwifery, being with woman, is beneficial and still desired and valued by laboring women. A review of recent research pertaining to women's perceptions of being with woman will help to determine if the concept is germane to consumers. Changes in childbirth practices from a social to a more medicalized event and the effects of technology, economics, and health organizations may have altered the balance between the need for being with woman and other midwifery and nursing activities. Finally, the review will examine the beneficial outcomes associated with being with woman suggested by research studies.

Midwifery and Being With Woman: Definitions

Midwife is defined by the *Random House Webster's College Dictionary* (1999) as a "person who assists women in childbirth" and "to assist in pro-

ducing or bringing about something new” (p. 838). Old English describes midwife as “mid,” meaning with and accompanying, and “wif” as wife/woman. This makes historical sense, because midwives were usually women (wives) who had born children themselves. The word *woman* has universally recognized meaning, with little if any controversy. Woman is defined as “adult human beings who are biologically female, that is, capable of bearing offspring” (p. 1500). According to one definition, *with* is a form of accompaniment, implying an interaction, a particular relationship or connection whereby participants display the same opinion or conviction. *With* also implies a spatial sense of proximity (*Random House Webster’s College Dictionary*, 1999).

A comprehensive literature search revealed the use of the word midwife (aside from nursing and midwifery) only in veterinarian medicine, where it is a colloquialism for assisting in animal births. In addition, Belenky, Clinchy, Gokldberger, and Tarule (1986) coined the term *midwife-teacher* in their book on women’s ways of knowing. Belenky et al. described the midwife-teacher as supporting and encouraging his or her students while also allowing them to think for themselves. Midwife-teachers “assist the students in giving birth to their own ideas, in making their own tacit knowledge explicit and elaborating it” (p. 217). Thus, midwife-teachers are present and available but do not tell the student what to do or how to think.

Midwifery Philosophy and Being With Woman

Regardless of the type of midwife or birth settings, all midwifery practice philosophies reflect the concept of being with woman during childbirth. The International Confederation of Midwives bases its philosophy on a partnership between the midwife and client (Guiland & Pairman, 1995). The American College of Nurse-Midwives (1989) has emphasized the importance of providing emotional and social support. The American College of Nurse-Midwives’ core competencies (1997), expected of every midwife, stress the importance of the therapeutic value of human presence. Frye (1995), a lay midwife who advocates home birth and lay midwifery, emphasized a holistic approach for practice. Midwifery is female-centered and integrated. Being with woman requires the midwife to be a skillful guide who supports and assists with her presence as she engages with the client in a one-to-one interaction. The Pew Health Commission for midwifery (Dower, Miller, O’Neil, & the Taskforce on Midwifery, 1999) reaffirmed this philosophy, stating that part of the midwifery model of care is continuous, hands-on assistance during childbirth. Kaufman (1993), a nurse-midwife and Canadian nursing professor, in a commentary about the control and medicalization of childbirth, described being with woman as a presence that includes physical, emotional, and psychological dimensions.

Midwifery’s Theoretical Perspective for Being With Woman

Theory building in nurse-midwifery is a relatively new phenomenon, which began approximately 15 years ago. Six studies and manuscripts were identified that could contribute to our knowledge of being with woman.

Thompson, Oakley, Burke, Jay, and Conklin (1989) marshaled the first efforts to define midwifery care by developing a middle range theory of nurse-midwifery care. Thompson et al. (1989) built upon a theory of caring borrowed from Benner (1984) and ways of knowing from Belenky et al. (1986). Their process for theory development was detailed and extensive. The underlying American College of Nurse-Midwives philosophy of nurse-midwifery (1989) formed the basis for the initial key concepts of the theory. Next, an interdisciplinary panel of experts (certified nurse-midwives, nurse

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researchers, consumers, and nurses) examined videotaped interactions between nurse-midwives and their clients to identify examples of midwifery care. Certified nurse-midwives responded to survey questionnaires to further develop components of the initial concepts. A thorough literature review was conducted to identify client indicators of satisfaction with certified nurse-midwife care. Of the six indicators identified, one included the physical and emotional support during labor that is an attribute of being with woman.

Lehrman (1988) developed a theoretical framework for intrapartum nurse-midwifery practice to describe relationships between components of nurse-midwifery care, psychosocial health outcomes, and maternal psychosocial variables. Through her work, a definition for the concept of *positive presence* was developed and summarized as “one on one personal attention and constant availability of the nurse-midwife for the woman in labor” (p. 44). In addition, Lehrman’s research results demonstrated that a positive presence by the nurse-midwife increased a woman’s self-esteem and satisfaction with the labor experience. Kennedy (1995) conducted a phenomenologic study of nurse-midwifery care from a feminist perspective, with the belief that midwifery provides care *with*

women not *to* women. Participants from two large practices with ethnically and economically diverse clients were interviewed. Foundations for the study were the work on caring of nursing theorists Watson (1985) and Leninger (1981) and previous work by Thompson et al. (1989) on the concepts of midwifery care. The birth settings varied from a high-technology Level III to a low-technology Level I hospital. Nine essential themes were formulated from 151 significant statements. Although many of the themes had characteristics of being with woman, one theme, “a continuous link with the nurse-midwife” (p. 415), was most representative. The participants perceived this to be continuous care and support and “a presence that was felt and valued” (Kennedy, 1995, p. 415).

Kennedy (2000) studied exemplary midwives and recipients of their care. Three dimensions of midwifery emerged: therapeutics, caring, and the profession. Maintaining a supportive presence and staying with the woman in labor as she desires, with adequate time to meet the woman’s needs, were processes of caring that reached strong consensus among the recipients of the midwifery care group. Stories by both groups supported the general theme of the “art of doing nothing well.” This theme was described by the midwives as supporting normalcy, being present, and not intervening unless necessary. Recipients’ descriptions included “being there” and “someone who rode the river with me” (p. 10).

Dickson (1996), an Australian midwife, developed a model of midwifery based on caring concepts borrowed from American work by nurse theorists Watson (1985) and Benner (1984), holistic nursing, and feminism. Her components of midwifery caring included the concept of *presencing*. Dickson used the work of Benner (1984) and Swanson (1993) to describe presencing as being with on both emotional and physical planes.

Physiological Basis for Being With Woman

Little research has been conducted on the physiological rationale for improved outcomes when a supportive presence is provided during childbirth. Anxiety, pain, and fear are known to increase catecholamines. Researchers have found that a sustaining human presence decreases the anxiety, pain, and fear a woman may experience in labor (Klaus, Kennell, Robertson, & Sosa, 1986; Smith, 1996; Sosa, Klaus, Robertson, & Urrutia, 1980). Animal studies (Adamson, Meuller-Heubach, & Myers, 1971; Barton, Killam, & Meschia, 1974) found that increased levels of catecholamines reduce uterine and placental blood flow, which perhaps contributes to pain. Human studies (Lederman, Lederman, Work, & McCann, 1985; Wuitchik, Bakal, & Lipshitz, 1989; Zuspan, 1962) found that cognitive concerns, pain, or anxiety concerning labor resulted in increased levels of catecholamines and longer labor with slower dilation rates. Furthermore, Saltenis (1962) studied the effect of nurses’ *high touch* (hand holding,

stroking) in labor as opposed to *clinical touch* (assisting with position changes and palpating contractions). High touch improved the woman’s coping ability and sensation of comfort and produced decreases in systolic blood pressure and pulse.

Qualitative Midwifery Research and Being With Woman

Recent research in midwifery has not addressed the specific concept of being with woman during childbirth. However, data concerning this concept are embedded in recent qualitative studies that explore women’s experiences of labor and birth with midwife care and women’s satisfaction with the childbirth experience.

Research that examined women’s perceptions of a midwife’s presence or experience of being with a midwife found that there are two types of providers: a caring and a noncaring midwife (Halldorsdottir & Karlsdottir, 1996a). Traits of a caring midwife included the attributes of being with woman and presence. The attributes of an uncaring midwife exemplified the absence of presence: being unsupportive, lacking competence, following routines and rules, and being cold and harsh. This phenomenologic study, based on 10 in-depth dialogues, identified the following caring attributes congruent with being with woman: giving the woman undivided attention, sharing the course of events, touching, and providing professional intimacy, connectedness, and support. Interestingly, being a caring midwife also included professional competence. In their descriptive study, Frazer, Murphy, and Worth-Butler (1996) also found competence (expert in human touch, communication, and active listening; discretionary privacy; professional judgments) to be a trait of presence. These conclusions appear to be appropriate and are supported by the *Random House Webster’s College Dictionary* (1999) definition of *presence of mind*: “The ability to think clearly and act appropriately in a crisis” (p. 1043).

In their phenomenologic study, Berg, Lundgren, Hermansson, and Wahlberg (1996) found that the essential structure of the midwifery experience was the midwife’s presence. They identified three subthemes: the midwife’s ability to see the client as an individual, support and guidance on the client’s terms, and a trusting relationship. Walker, Hall, and Thomas (1995) also developed themes from postdelivery interviews with women who were cared for by midwives. One theme, perceived support, included someone who provided confidence and who could be trusted.

Ten other qualitative studies looked through the lens of women’s experiences with midwifery care. Women believed a positive birth experience with their midwife was associated with a caring, trusting, flexible relationship with shared responsibility, co-participation and midwifery guidance, and companionship (Bluff & Holloway,

1994; Hall & Holloway, 1998; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996; Walker et al., 1995; Walsh, 1999). Laboring women also valued support from the midwife (Hall & Holloway, 1998; Halldorsdottir & Karlsdottir, 1996b; Lavender, Walkinshaw, & Walton, 1999; Leach, Dowswell, Hewison, Baslington, & Warriolow, 1998; Tarkka & Paunonen, 1996; Too, 1996; Waldenstrom et al., 1996; Walker et al., 1995), sensitivity to needs (Too, 1996; Waldenstrom et al., 1996), and reassurance (Halldorsdottir & Karlsdottir, 1996b; Too, 1996). Other themes supportive of the concept being with woman from the woman's perspective were clinical expertise (Bluff & Holloway, 1994; Frazer, 1999), control in decision making (Berg et al., 1996; Bluff & Holloway, 1994; Halldorsdottir & Karlsdottir, 1996b; Too, 1996; Walker et al., 1995), and advice and information from the midwife (Lavender et al., 1999; Leach et al., 1998; Too, 1996).

Qualitative studies of women's perspectives and experiences of childbirth with midwives found that women value the nurse-midwife's concept of being with woman. Themes reflected many of the adjectives found in Lehrman's (1988) definition of positive presence, "the extent to which the nurse-midwife's response to the laboring woman encompasses the high touch qualities of nurturance, intuitive awareness, sensitivity, personal attention, knowledge, professional expertise, and presumed validity of the individual woman's subjective experience" (p. 44). That none of these studies was conducted in the United States underscores the need for and the importance of further research concerning women's experiences of nurse midwifery presence in the United States.

Theoretical Perspective of Presence for Nursing

Numerous nursing theorists and authors (Benner, 1984; Leninger, 1981; Parse, 1990, 1997; Patterson & Zderad, 1976; Swanson, 1991; Watson, 1985) have included the concept of presence as a building block of their theories for nursing care and practice. Not surprisingly, they all have similar philosophic tenets that emphasize the uniqueness of each nurse-client interaction.

Benner (1984) stated that presence was one of the eight dimensions associated with being an expert nurse. In her work, presence was defined as a "being with" that encompassed behaviors such as touching, being a good listener, understanding the lived experience of the client, and sharing her humanity. Watson (1985) did not specifically develop the concept of presence in her theory. Through her description of the transpersonal nurse-client relationship, however, she alluded to the process as a sharing of each other's phenomenal field and identification with each other intersubjectively and wholly, which goes beyond mere physical care. The helping-trusting relationship connotes presence, accepts both positive and

negative feelings, and demonstrates the congruence of the nurse or midwife with the client. Parse (1990) stated that the nurse interrelates and co-constitutes by her personal presence. Coexistence involves "being with others," and nurses freely choose ways of "being with situations." Parse (1997) described true presence as the experienced connection between the nurse and client. Patterson and Zderad (1976) embraced the theoretical concept of presence. The intersubjective transaction between nurse and client includes presence. Patterson and Zderad's (1976) main domain of nursing therapeutics involves not only doing but also the active presence of being, which includes such behaviors as comfort, nurturing, support, experiencing, reflecting, and conceptualizing.

Swanson's (1991) middle range theory of caring includes the caring process of "being with." The theory was developed from three phenomenologic studies in obstetrics. She defined this process as being emotionally present for another and able to be in the client's reality. This theory was validated (Benner, 1984) through examination of the helping roles of the nurse and conceptual caring processes (Watson, 1985).

Presence Defined by Nursing

The work of numerous nurse researchers and analysts (Fuller, 1991; Gardner, 1985; Gilje, 1992; Minicucci, 1998; Mohnkern, 1992; Osterman & Schwartz-Barcott, 1996) was reviewed to reach a definition of presence from the nursing literature. Presence involves a willing interaction between nurse and patient that requires trust by the patient, and a giving of self (engagement, attentiveness, time, awareness of the encounter) by the nurse. Presence is defined as both a physical "being there" and a psychological "being with." Outcomes of presence, similar to being with woman, are considered to be positive, social, spiritual, psychological, or physical outcomes or interactions.

Gilje's (1992) concept analysis and review stated that being with is the most common definition of presence. Gardner (1985, 1992) discussed how psychological support is a part of presence and that the support may involve physical touch or closeness. The being with woman of midwifery and presence as defined by midwifery/nursing has a related concept with overlapping attributes as defined by childbirth care providers, nurses, and midwives: *social support*.

Social Support in Labor

It is important to review the quantitative research on social support in labor for two reasons. First, it is virtually the same concept as being with woman and presence. Variations on the definition include numerous attributes such as physical touch, comfort, emotional support, information giving, and helpfulness and come from all fields (psychology, nursing, and sociology) and theoretical bases (caring, communications, relationship, advocacy).

Second, numerous quantitative studies have demonstrated a definite association between social support in labor and beneficial maternal/neonatal outcomes. These studies provide striking evidence for the use of a continuous midwife/nurse presence during labor and birth. Social support as defined by Hodnett (2000), a nurse researcher and expert on the concept, is “the three dimensions of advice/information, tangible assistance, and emotional support (presence, listening, reassurance, affirmation)” (p. 2). A willing relationship between the giver and recipient of care is also implied.

Instead of instituting social support by a midwife or nurse to enhance beneficial childbirth outcomes, the obstetric community in the United States chose to use more technologically and biomedically based interventions.

In the 1980s, two studies conducted in Guatemala demonstrated how the continuous presence of a supportive female companion (a doula) during childbirth could reduce the rate of cesarean section, increase maternal-newborn bonding, and shorten the time of labor (Klaus et al., 1986; Sosa et al., 1980). The word *doula* is a Greek derivation meaning an experienced female who guides and assists a new mother. Although these were standard scientific randomized controlled studies, physicians believed it was important to replicate them in the United States under modern obstetric conditions so that results, if replicable, could be generalized. The biggest difference between obstetric practices in the two countries was the United States’ increased use of interventions and technology such as electronic fetal heart rate monitoring, epidural anesthesia, oxytocin, and artificial rupture of membranes to augment labor.

Kennell, Klaus, McGrath, Robertson, and Hinkley (1991) replicated the randomized and controlled study in the United States with a sample of 412 nulliparous women. The doula stayed with the woman during labor, providing touch, encouragement, information, and an explanation of hospital procedures. Doula support significantly reduced the rate of cesarean section and forceps delivery for the experimental group. In addition, the use of social support decreased oxytocin use, shortened the duration of labor, lessened prolonged infant hospitalization, and decreased the chance of maternal fever.

These three studies were significant because their prospective nature and quantitative method allowed the

effect of continuous social support to be isolated from other variables. Kennell et al. (1991) concluded that not only was a continuous presence emotionally and physically beneficial to the mother, but the use of presence could also represent substantial cost savings for health organizations.

It is difficult to understand why the results of the studies described above have not been used to guide women’s health care and policies. Instead of instituting social support by a midwife/nurse to enhance childbirth outcomes, obstetric care providers in the United States instead chose to use more technologically and biomedically based interventions. A prime example of this is the adoption by many hospitals and care providers of part of the “active management of labor system” advocated by England’s O’Driscoll and Meagher in their book (1980) and the follow-up study by O’Driscoll, Foley, and MacDonald (1984). The three-pronged “active” approach consisted of early artificial rupture of membranes, aggressive use of oxytocin, and the continuous presence of a one-on-one midwife. With this approach, there was a marked decrease in the length of labor and the need for cesarean birth. Since the mid-1980s, hospitals have aggressively used the first two technologic interventions of the program but the third, the continuous one-on-one midwife presence, has not been adopted or advocated.

Further evidence for social support in labor is provided by Hodnett’s (2000) meta-analysis, which examined 14 randomized controlled trials of continuous woman-to-woman (midwives, doulas, nurses, women) support of healthy laboring women. The benefits of continuous labor support were impressive. They included fewer operative deliveries, fewer cesarean sections, less need for analgesia and anesthesia, fewer low Apgar scores, fewer women with negative views of their childbirth experience, greater maternal satisfaction, a sense of control with the childbirth experience, and fewer problems with coping during the experience. The beneficial outcomes identified from qualitative studies by Hodnett were less postpartum depression, longer breastfeeding, and better adaptation to motherhood.

The 14 trials in Hodnett’s meta-analysis included approximately 5,000 women. Three trials had the continuous presence of a midwife during labor (Breat et al., 1992). Two other trials used midwifery students (Hemminki et al., 1990) to provide social support during labor. It is significant that of all 14 studies, only 2 used nurses to provide support and the nurses were hired especially for the studies. The women in the control groups for the studies received routine nursing care, which suggests that in general the nurse is not with or providing presence or support for the laboring woman.

Two Canadian studies underscore the premise that nurses might not routinely provide social support or a sustaining human presence during labor. The study set-

tings were remarkably similar to American hospitals, with a one-to-one or two-to-one patient-to-nurse ratio and a large percentage of epidurals, which required added technology (electronic fetal heart rate monitoring, intravenous lines, etc.). McNiven, Hodnett, and O'Brien-Pallas (1992) looked at nurses' supportive care during labor and birth via 616 random work sampling observations of 18 nurses. Supportive care consisted of emotional support, physical comfort measures, information giving, and advocacy. When all activities were compared, the nurse spent only 9.9% of her time providing supportive care: most in the form of giving instruction or information to the woman. Only two instances of reassuring touch were observed. One half of the nurse's work activities did not involve being with the woman.

Gagnon and Waghorn (1996) conducted a work sampling study of intrapartum nursing activities in a large urban hospital where intrapartum nurses usually had a two-to-one patient ratio: one patient in early labor and one closer to delivery. Four 3rd-year nursing students trained to look for supportive care behaviors made over 3,367 random observations. Only 6.1% of time was spent in supportive care. Of this total percentage, 50.5% of the support was instruction and information, 5.8% advocacy, 26.7% physical comfort, and 17% emotional support. Ironically, most of the nurses' time (74.9%) was not spent in the laboring woman's room. Of note, these studies have not been replicated in the United States for intrapartum nurses nor have any work sampling observations been conducted for midwifery.

Discussion

This analysis demonstrated the clear theoretical, philosophical, physiological, and empirical basis for being with woman as a central concept of the model of care for women in labor. In general, being with woman, a midwifery concept, is defined as presence by midwifery/nursing professionals and social support by obstetric care providers. Antecedents are a willing and desired relationship between the midwife/nurse and the woman for which the care provider acts as a companion and guide. The two most representative attributes of being with woman are providing available human presence and social support as indicated by the woman's perceived needs: emotional, physical, spiritual, and psychological. From a physiological perspective, decreased anxiety, pain, and fear can contribute to a shorter labor and presumably better birth experience.

The qualitative research review demonstrated that women still value and desire the attributes of being with woman. Qualitative and quantitative studies document the beneficial maternal/neonatal outcomes of being with woman. The review of the concept being with woman supports the clear need for it to remain a routine part of

midwifery/nursing clinical practice or be incorporated as such.

Being With Woman, Midwifery/ Nursing Practice, and Health Policy

The real crux of the matter for both midwifery and nursing is to decide as professions who is going to define our philosophy of practice. If we choose to define ourselves, the principal question must be, "What is our main responsibility to our clients?" If we choose caring, then it is evident from work sampling studies (Gagnon & Waghorn, 1996; McNiven et al., 1992) that we must find a way to make sure that nurses and midwives remain at the bedside. If we let the biomedical model, medical profession, and hospital administration drive our clinical practice, then technology, quantity versus quality care, and managing the care of the patient instead of caring for the patient will become our priorities. The latest example of this in obstetrics is the growth in the use of doulas (Simkins & Way, 1998) to provide the sustaining human presence and companionship for the laboring woman that the midwife/nurse is capable of providing.

Midwives and nurses are concerned that technology is becoming more important than caring to those who provide childbirth services (Buus-Frank, 1999; Oakley, 1989). For instance, health policy mandates one-to-one care for patients who receive the drug oxytocin because of the very small risk, if used judiciously, of uterine rupture. However, if a laboring woman chooses nonintervention or does not require technological interventions such as oxytocin or continuous fetal monitoring, she is often part of a midwifery/nursing caseload of three or more patients. Increasingly, midwifery/nursing has been forced to practice under administrative health policies that do not value

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or understand the time intensiveness of being with woman that produces satisfied clients and beneficial outcomes. This is incongruent with evidence-based knowledge citing the benefits of a sustaining human presence during childbirth (Hodnett, 2000).

The Maternity Center Association (1998), an 80-year-old nonprofit agency for maternity concerns, has stated that the consistent presence of a supportive provider dur-

ing labor and birth should be a guaranteed right for all women. The Coalition for Improving Maternity Services (1996) espoused the same beliefs concerning unrestricted access to continuous emotional and physical support from a skilled woman in their Ten Steps of the Mother-Friendly Childbirth Initiative.

Our midwifery/nursing philosophy, theory, and models of care, which all emphasize being with woman, presence, and caring as a central tenet, must dictate our practice and shape health policy. To influence health policy, midwives and nurses must become a more powerful presence in hospital administration and the health care arena. We must advocate for the benefits of the being with woman model of care, stressing consumer satisfaction, improved outcomes, and cost savings.

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