All you need is a dark space and a good midwife: An exploration of the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings

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Abstract

Title: All you need is a dark space and a good midwife: an exploration of the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings

Background: There is sound evidence that UK maternity services should be based on the model of midwifery led care in situations where pregnancy and birth are expected to be straightforward, a view underpinned by evidence from systematic review and other research (Hollowell et al., 2011, Sandal et al., 2016) and government recommendation (NICE, 2014; NHS England, 2016). The idea of midwives occupying professional leadership positions within maternity services is not a new one, and first found formal recognition in the Changing Childbirth report (1993) which, as government policy, became a major influence on thinking about how services should be organised. The implication was that midwifery led care was the appropriate choice for women regarded as being at low risk of complications. Despite the wealth of more contemporary literature supporting the model it is not entirely clear what defines and makes it an effective pathway i.e., the strategies and techniques are used by midwives to interact with women, particularly in intrapartum care, and the impact on practice of midwifery led birthing environments. Though such matters have been explored by looking at qualities and outcomes of midwifery led care separately, a comprehensive in-depth exploration and analysis is lacking.

Methodology: The study uses a qualitative case study approach to examine the strategies, techniques, and practices used by midwives to enact the attributes of midwifery led care, thereby increasing our understanding of the model. Four defining attribute themes of midwifery led care were ascertained through a process of concept analysis. An Alongside Midwifery Unit (AMU) and a Freestanding Midwifery Unit (FMU) were recruited as the 'cases'. The study received Ethics Committee and Research Governance Committee approval. Direct non participant observation of midwifery intrapartum care, follow-up interviews with the

midwives, and document analysis, were data collection methods. Framework analysis was used to analyse the data across the two cases. The Framework method is an example of thematic analysis or qualitative content analysis used in qualitative research that allows for comparing and contrasting data across and within cases. Data collection for case 1 (AMU) took place from March to August 2016. During this period 1 birth was observed and 9 midwife interviews took place. A number of documents were collected for review relating to different aspects of the AMU's service. Data collection for case 2 (FMU) took place from March 2017 to October 2017. Two births were observed and 7 midwife interviews were recorded.

The four defining attributes of midwifery led care were overall themes of the study. Data collected was organised in relation to the themes. Data analysis resulted in each theme containing several related sub themes. For example, the first of the defining attribute themes, 'the midwife is the lead professional and acts as an autonomous practitioner' gave rise to the sub themes: leading care through expertise, advocating for women, and problematic autonomy. Open coding revealed 2 additional themes: preserving self and working together.

Findings: Research participants identified with and verified the relevance of the defining attributes of midwifery led care. It has been possible to assemble a picture of how the attributes are enacted in midwifery led settings. Some of the findings represent features of this model of care which have hitherto not received comprehensive attention in contemporary literature. A conceptual model for the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings has been developed as a result of this research.

Conclusion: The findings address the need to deepen knowledge of midwifery led care in environments where midwives are the responsible professionals for labour and birth, at a time of great upheaval of maternity services and the development of midwifery led continuity of care models. This research study contributes to the

background picture of midwifery led care and provides novel perspectives that can be taken into consideration when developing maternity services.

Table of Contents

List of Figures

List of Tables

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Chapter 1 Introduction

1.1 Introduction and background

Since the beginning of the 20th century, maternity and midwifery services have been characterised by tensions between professionals involved in delivering care, and struggles by midwives to assert themselves as autonomous practitioners (Robinson, 1991). Walton and Hamilton (1995) described a situation in the decades of the 1970s and 1980s where '… technology was rapidly taking over the care of the childbearing woman.' (p. vi). In fact, the second report of the Social Services Committee, known as the Short Report (House of Commons, 1980, cited in Walton and Hamilton, 1995) though recommending the phasing out of home births in the UK, did accept the detrimental effect increasing centralisation of services had on midwifery practice and morale. Hodnett et al. (2012) referred to the increased incidence of routine medical interventions and the unanswered questions of the benefits these interventions conferred to healthy populations of women. These competing phenomena have also been discussed by Walsh (2003) who pointed to the increasingly risk averse culture of care despite relatively low rates of mortality and morbidity. More recently there have been discussions about maternity services on a global scale, and resolution to correct situations of 'too little too late, too much too soon' (Miller et al., 2016). This commentary on the continuum of global maternal healthcare, draws attention to extremes in provision of services and outcomes. 'Too little too late' represents services where resources are inadequate, unavailable, withheld, or associated with below evidence-based care. 'Too much too soon' characterises over-medicalised care, where routine interventions in normal pregnancy and birth do not lead to better outcomes or avoid poorer outcomes or harm.

For the 21st century, and the last decade of the 20th century, midwifery led care has been a defining feature of the maternity services in the UK. The Idea of midwives being lead professionals in maternity care has been driven by government policy

since the House of Commons Maternity Services Committee published its report into the maternity services (House of Commons, 1992). The House of Commons report (1992) contended that despite continued falls in perinatal mortality and very low rates of maternal mortality, i.e., increased safety for women and babies, the service was not meeting the needs of its users with respect to providing a satisfying and life enhancing experience. The introduction to this report referred to the underlying normality of the process of childbirth; the concluding chapter, with its vision for the future, eschewed the idea that birth could be normal only in retrospect, regarding this view as an obstacle to women having control over the care they received. The report gave formal recognition and acceptance of midwives leading care in situations of normality and low risk. The government responded to this in the publication of Changing Childbirth (1993), which was a major influence on thinking about how maternity services should be organised. It considered what the roles of professionals providing the service should be and the involvement of women users of the service. The implication was that midwifery led care was the appropriate choice for women regarded as being at low risk of complications (DH, 1993) i.e., the possibility of midwives assuming roles of lead professional for women with uncomplicated pregnancies mirrored the conclusions of Winterton (House of Commons, 1992).

In years to follow, other evidence focussing on maternity services would echo the recognition of midwives' specific contribution to childbirth outcomes. The National Service Framework for Young People and the Maternity services (DH, 2004) advocated the promotion of midwifery led care where appropriate, the provision of midwifery led units either on the same site as consultant led obstetric units ('alongside' or AMU) or in freestanding units, (where facilities are located away from the site of the obstetric unit and without access to specialist anaesthetic and neonatal services), and the provision of home birth services. This was reflected in the choice guarantees, enshrined as UK government policy in 2007 (DH, 2007), where women were to be assured of having choices available to them about place of birth. The Birthplace in England Study (Hollowell et al., 2011) established that

women considered to be at ' low risk' of obstetric complications, and particularly multiparous women receiving intrapartum care in midwifery led birth facilities such as an alongside midwifery led unit, could expect safe care (good maternal and perinatal outcomes such as reductions or no difference in meconium stained aspiration syndrome, brachial plexus injury, or intrapartum stillbirth) and a reduced amount of intrapartum interventions, when compared with similar women labouring and giving birth in consultant obstetric led units. Furthermore, the most recent guidance from the National Institute of Healthcare Excellence (NICE, 2014) has incorporated the evidence from the Birthplace in England study (2011) to recommend that both multiparous and nulliparous low risk women should be advised that giving birth in midwifery led units is particularly suitable for them.

That midwifery led care has been accepted as part of the architecture of maternity policy has been cemented, to some extent, by current maternity policy in the form of 'Better Births' (2016), the latest review of maternity services in England. The underlying evidence behind policy decisions is also convincing. In the research literature, systematic reviews such as that conducted by Sandall et al. (2016) comparing midwife-led continuity models of care throughout the childbirth continuum with other models, included 15 trials involving 17 674 women, from studies that had taken place in Australia, Canada, Ireland, and the UK. The review found that fewer women randomised to midwifery led care had epidurals, experienced preterm birth, or pregnancy loss, had episiotomies or instrumental births than those assigned to other models of care. The midwife led care model was also associated with a greater probability of spontaneous birth, and knowing the intrapartum care midwife. There were no differences in numbers of caesarean sections. These findings indicated the significance of midwife led care in facilitating straightforward normal childbirth. Ten studies from this review reported on maternal satisfaction. They suggested greater satisfaction with midwife led continuity models than other models.

What women wanted of childbirth services, and valued as outcomes, was also investigated via a systematic review (Downe, 2018) carried out to contribute to the World Health Organisation's (WHO, 2018) intrapartum guidelines development. 37 studies were included in the review, originating from all regions of the world. The primary outcome for pregnant women was a positive birth experience. This experience consisted of more than a healthy baby; women also wanted competent and kind clinical staff, and psychologically safe environments. The review found that most women highly valued their own ability to give birth physiologically, but recognised that interventions might be necessary.

The landscape of maternity services and midwifery practice is shaped by UK maternity services policy. It is clear from the direction of policy recommendation, and research evidence presented above that midwifery led care is supported and remains a linchpin of policy. In the UK, antenatal, intrapartum, and postnatal care is provided mostly by midwives. In 2018 there were 731,213 live births in the UK (Office for National Statistics, 2019). Although data on midwife facilitated births is not easily available, in 2010, the Midwifery 2020 report suggested that they were the main providers of intrapartum care (2010). During the same period, in the intrapartum context, interventions such as artificial rupture of membranes, induction of labour and epidural analgesia were accepted and embedded within the structure and organisation of services (Crabtree, 2008) despite consensus opinion that the majority of women were capable of giving birth with a minimum of obstetric procedures (Maternity Care Working Party, 2007). More contemporary data analysed via the National Maternity and Perinatal Audit demonstrated that 'spontaneous' vaginal birth[1] was the single most common outcome of pregnancy

[1] In this audit, spontaneous birth was defined as vaginal without the assistance of instruments.

for women giving birth to a singleton baby in cephalic presentation, at 37 to 42 weeks gestation included in the analysis[2]. What is not clear is what defines midwifery led care, and how midwives operating in midwifery led care settings, particularly intrapartum care, shape their practices, making it an effective pathway which might result in positive birth experiences for women. Details of techniques, strategies and practices making up the package midwifery led intrapartum care have not been studied directly. Yet it is important to critically examine how this arrangement of care is enacted, and what the perspective of the midwives carrying out midwifery led are, to gain deeper understanding and knowledge of this fundamental aspect of maternity service provision.

1.2 Justification for the study and contribution to knowledge

Baldwin and Rose (2009) suggested that gaps in understanding such as how midwifery led care is defined, and how midwives operate in midwifery led settings, could be addressed through the methodology of concept analysis. As there was no evidence from the literature that midwifery led care had been the focus of such an exploration before, a concept analysis of midwifery led care was carried out. Through this exercise components of midwifery led care that could be regarded as its exemplars, distinct from other concepts or models of care, were identified. The concept analysis established defining attributes of midwifery led care that were associated with its underpinning beliefs of midwifery (childbirth is a normal life process; women are capable of physiological birth without intervention) and underlying core practices of midwifery (providing continuity of care/carer; association with fewer interventions). Uncovering the defining attributes and their

[2] Data from 449 539 births was included, gathered over a period 1st April 2025 to 31st March 2016, from Great Britain, and reported in 2017.

associated themes led to questions about how they were operationalised, or enacted in intrapartum midwifery led care settings. Bryman (2004) suggested that the process of deriving a research question was supported by personal experience and interests or the desire to test theories, and tackle social problems. Previous literature emphasised positive clinical outcomes of intrapartum midwifery led care but did not consider the mechanisms by which it is carried out by midwives in clinical practice. Thus, the subject area lacks a comprehensive conceptual framework that can provide insight into and in-depth analysis of the defining attributes. The purpose of current research study was to carry out a detailed exploration of the defining attributes through the lens of midwifery practices and to develop an appropriate conceptual model. A comprehensive exploration of how midwifery led care is enacted is particularly pertinent at a time of increasing recognition and support for adopting this model of care.

1.3 Research aim

The purpose of the study was to explore the strategies, techniques and practices used by midwives working in midwifery led intrapartum care settings in enacting the defining attributes of midwifery led care. The study sought to deepen understanding of midwifery led care and make visible mechanisms of midwifery practice within this model of care.

1.4 Research question

'How are the defining attributes of midwifery led care enacted in intrapartum midwifery led settings?'

The research question developed following the concept analysis, which identified defining attributes of midwifery led care. It was envisaged that undertaking this

study and addressing the research question would add to the knowledge already gained from systematic reviews about the benefits of midwifery led care and what it comprises.

1.5 Overview of the thesis

This thesis presents the study exploring the enactment of midwifery led care in midwifery led intrapartum care settings. It consists of a multiple case study of two selected cases.

Chapter 1: The introduction presents an overview of the UK landscape of midwifery led care, which encompasses intrapartum care. It discusses the current challenges of midwifery led care as a policy objective, and the lack of definition of the concept. Chapter 1 also introduces the need for a concept analysis, advances the justification of the study, and identifies the research question and the aims and research study.

Chapter 2: The concept analysis of midwifery led care is presented in this chapter, resulting in defining attributes being identified. The rationale for the methodological decisions of the concept analysis is outlined. The concept analysis process includes developing a model case of midwifery led care, used during interviews with midwives. Defining attribute themes are explored in the literature review.

Chapter 3: This chapter consists of the literature review of defining attributes of midwifery led care. The search strategy is described, which resulted in relevant literature being synthesised for each of the defining attribute themes. This enhanced and expanded the concept analysis, and provided clarity on how the defining attributes are represented in wider literature.

Chapter 4: The methodological approach used for the study is outlined, including an explanation of its suitability for social research. Suitability is contingent on

selecting a methodology whose philosophical orientation matches the aims of the study and research question. The chapter includes a discussion on philosophical orientation.

Chapter 5: A detailed account of the design and methods used in conducting the research is provided here. This includes ethical considerations and data collection methods used. The chapter also includes the data analysis process.

Chapter 6: The first of the findings chapters, it presents findings that relate to how the predetermined defining attributes of midwifery led care are enacted. The chapter presents interpretations of the perspectives of midwives and findings from observing midwifery practice.

Chapter 7: The second of the findings chapters, it presents findings from open coding, i.e., the themes inductively developed that give insight into contextual factors of midwifery led care. Findings from Chapter 7, though of interest in themselves, are tangential for addressing the research question, and represent new information not addressed in the literature review.

Chapter 8: This chapter discusses the findings from chapter 6, revealing how midwives enact the defining attributes of midwifery led care, and thereby addressing the research question. This chapter also outlines how the thesis has both enhanced existing knowledge, and uncovered novel understandings of the enactment of midwifery led are. The chapter then looks at the research's strengths and limitations, and makes recommendations for practice, education, and future research.

Chapter 2 Defining the attributes of midwifery led care, a concept analysis

2.1 Introduction to concept analysis

The background for this research study (Chapter 1) discussed how previous and current maternity services policy endorsed midwifery led care as an organising principle in situations of normality (Department of Health, 1993, 2004 and 2007; NHS England, 2016). Whilst endorsing this plan, however, it is not always clear from policy documents and other literature what defines midwifery led care. The RCM, for example, referred to this model in its position statement on women centred care(WCC) (2008). WCC was considered a valuable attribute as it focussed on women's individual needs and sought to involve them in decisions and planning about their childbirth experiences. Midwives acting as lead professionals were regarded as part of that process, yet there was a lack of clarity about what midwifery led care meant. Baldwin and Rose (2009) proposed that concept analysis addressed the issue of lack of definition in such situations because the methodology resulted in expanding the body of knowledge held about a particular issue. A concept analysis was carried out to explore the defining attributes of the issue, and provide clarity about the concept of midwifery led care. The aim of conducting the concept analysis for the current research was to discover the components of midwifery led care that were accepted as being its exemplars, distinct from other concepts or models of care. Clarifying this issue was the starting point of the research, and contributed directly to answering the research question.

2.2 Methodology of concept analysis

The methodology of concept analysis has been used in health science literature to express meanings of a variety of phenomena, from 'normal birth' and 'normal

labour' to 'one to one support', 'capacity building', 'listening' and 'maternal-infant bonding' (Anderson, 2003; Sosa et al., 2011; Condell et al, 2007; Shipley , 2010; Kinsey et al, 2013). Walker and Avant's (2011) methodology consists of an eight-step process that begins with the selection of a concept of interest. The concept of interest, they advised, should be important either to further a research project, or to contribute to specific theory development. Following these steps came the formulation of a model case, which included the common characteristics, or defining attributes. Walker and Avant's (2011) schema also required that additional cases such as borderline, related, and contrary and illegitimate cases were identified. The purpose of this part of the exercise was to differentiate instances where the concept of interest was either closely aligned to (related and borderline) or contrasted significantly with (contrary or illegitimate) other concepts, in order to isolate further its true attributes.

The analysis was completed by two further tasks i.e., identifying antecedents and consequences of the attribute, and its empirical referents (2011). Walker and Avant asserted that theory construction relied on assembling a solid basis of concepts that had defining characteristics and clearly delineated meanings. They pointed to the tentative nature of the end product of the analysis, which reflected the '...dynamic quality of ideas ...' contained within the concept (2011, p 158). Anderson (2003) described empirical referents as indicators which could be used to assess the validity of the key defining attributes, identifying both a model case and alternatives such as contrary cases. These outputs expressed what the concept was not (Walker and Avant, 2011). Thus, the result of subjecting a concept to this scrutiny was an '...operational definition, a list of defining attributes, and antecedents....' (Anderson, 2003, p 158).

Chinn and Kramer (2011), in their discussion of how knowledge is developed, argued that there was a tentative aspect to the criteria used to expose the meaning of a concept. This implied that meanings could evolve and change where new and different ways of understanding a concept came into being. They proposed that

concepts could be located along a continuum, with the relatively empiric and the relatively abstract occupying either end. Thus, in selecting a concept for further investigation, they counselled that if located at these extremes, there may be problems when exploring what their meanings were. Thus, a concept that was highly empirically knowable, or one that by contrast was broad, encompassing many meanings, could both be problematic.

Chin and Kramer (2011) outlined a process of concept analysis that consisted of establishing an 'exemplar case' as the initial exercise. The exemplar case demonstrated the quintessential character of the concept such that there was no doubt about the object of the analysis. This was explained in their statement '"If this is not x, then nothing is"' (p166). Walker and Avant's approach to concept analysis included drawing upon as many sources as possible in order to identify all uses of the term, thus , physical aspects, implicit and explicit uses i.e., the 'ordinary and scientific' were all valuable to the study (2011). The resultant analysis was therefore influenced by both colloquial and theoretical meanings, which contributed to constructing the defining attributes of the concept. However, substantial criticism of this approach has been forwarded (Paley, 1996 and Risjord, 2009).

Risjord (2009), commenting on the 2005 version of Walker and Avant's (2011) schema, reproduced an outline of its philosophical roots. In this reproduction, examples, or cases, of concepts were developed to demonstrate their natural and common uses. Contrary and related cases were then designed to aid in isolating the defining principles. In this way, cases were said to represent the meanings of concepts. Eventually, the products of this process would lead to evidence for the meaning of a theory. Risjord (2009) disagreed with the procedure used by Walker and Avant (2011). He pointed to a fundamental ontological difference in the ways that concepts and theories were perceived. Concepts were either the 'building blocks' of theories, or arose from theories, with their meanings being derived from the context that theories existed in. The conclusion from this argument was that in

attempting to derive characteristics of a concept, evidence from 'scientific' or research based literature should not be blended with evidence from colloquially based sources, because they were situated in different contexts. Instead, concept analyses should be either distinctly theoretical or distinctly colloquial. In the subsequent edition, Walker and Avant (2011) addressed these difficulties and defended the value of their system as an aid to understanding the meanings of concepts and the development of theory. The literature suggested, therefore, that concept development or analysis was problematic because of disagreement about philosophical influences of the varying approaches and the methods used to achieve a useful product. (Risjord, 2009; Paley, 1996)

Rodgers (1989) proposed an alternative process for concept analysis to that offered by Walker and Avant in 1983 (although it should be recognised that Walker and Avant's most recent work was published in 2011). In her view devising contrary, borderline, or illegitimate cases, i.e., situations that opposed the ideal case, resulted in a static concept. She was concerned that a static concept would not take interrelationships of ideas into account, nor would it adapt to developments in understanding and knowledge of a given area. The system employed by Rodgers (1989) claimed to identify what was common in the existing view of the concept, without including strict criteria of what it was and was not. She emphasised the evolutionary and dynamic nature of concepts, and thereby, the fact that they were subject to change. She created a seven step approach to concept analysis which is illustrated in Table 2.1.

Rodger's Method of Analysis (1989)	
1	Identify and name the concept of interest
2	Identify surrogate terms and uses of the concept
3	Identify and select an appropriate realm (sample) for data collection
4	Identify the attributes of the concept
5	Identify the antecedents and consequence of the concept if possible
6	Identify concepts that are related to the concept of interest
7	Identify a model case of the concept

Table 2-1 Rodger's seven step method for concept analysis

Rodgers' (1989) system is a revised approach to that popularised by Walker and Avant in 1983. It excludes the steps that would lead to identifying related cases, i.e., the contrary, invented, and illegitimate. Her decision to abandon these aspects of the methodology was influenced by a belief that the concepts should not be viewed as being associated with rigid boundaries, instead, the interrelationships between them were acknowledged. The method used for analysing the concept of midwifery led care was influenced by Rodger's methodology, and included aspects of Walker and Avant's (2010) methods which were compatible. The combination of these two positions was uniquely developed by the researcher. It represented the researcher's experiential knowledge of the fluidity with which childbirth is conceptualised, both over time and within the same time period. These

conceptualisations can be explained for example, by different philosophies of care stemming from social or medical models[3].

2.3 Surrogate terms

English language and midwifery dictionaries were searched for uses of the words 'midwife' 'led' and 'care' before considering 'midwifery led care' (Collins 2011, Oxford 2010, Winson and McDonald, 2005). The dictionaries were used to build a picture of everyday uses of the separate words and to identify so called surrogate terms. The findings are presented in Table 2.2.

[3] The social and medical model are 2 overarching models of health. Their importance for childbirth, including organisations of services, is explored in the discussion section of this thesis.

Dictionary Uses of 'Midwife'	Dictionary uses of Led (Lead)	Dictionary uses of 'Care'
A person qualified to deliver babies and to provide care for women before, during and after childbirth	To show the way to an individual or group, going ahead. To guide or be guided by. To cause to act, think, feel or behave in a certain way. To guide control or direct.	To be troubled or concerned; be affected emotionally To have regard, affection of consideration To have a desire or a taste for To provide physical needs for, help, or comfort for
(Midwifery) The professional providing assistance and medical care to women undergoing labour and childbirth during the antenatal, perinatal and postnatal periods	Cause to go with one Direct the actions or opinions of Guide by opinion or example or argument Provide access to; bring to a certain decision or destination Be in charge of	To feel concern or interest To take care or thought To have regard or liking for, to be inclined to
A person trained to assist women in childbirth. Mid with + Wife woman, in the sense of one who is with the mother.	The action of lead Direction given by going in front Something that leads Theatre: the principle part in a play Card playing: the action or right of playing the first card in a round or trick (Shorter Oxford English Dictionary vol 1, 1978)	
The art and science concerned with caring for women and their families during normal pregnancy, labour and the postnatal period.		

Table 2-2 Sources: Illustrated Dictionary of Midwifery; The concise Oxford Dictionary; The Collins English Dictionary

Dictionary definitions of 'midwife' covered the activities of a person assisting a woman, or woman and family in the period of childbirth. This activity was commonly recognised as starting in pregnancy and extending to the postnatal period, reflecting the contemporary picture. One definition (Oxford, 2010) defined

'midwifery' rather than midwife, and included the giving of medical care. The words 'assistance' and 'caring' were used. There is appreciation of professionalism and the expectations of training and qualifications. Bailliere's Dictionary for Midwives (2005) provided insight into the scope and ethos of midwifery practice, and included elements of artistry and normality in its definition. The consensus of these definitions saw a midwife as being a trained person, or professional, caring for women (and families) throughout the spectrum of childbirth, and not confined to during labour.

Uses of the word 'lead' or its past participle 'led' were considerably more varied and numerous. In examining different definitions of this word, however, it was possible to discern ideas that frequently replicated themselves, despite arising in different contexts (card playing, curling, theatre). However, there were instances where, due to their specialist nature (electricity, mining, engineering) aggregation would not have been useful. Paley (1996), in his critique of methods used and underlying assumptions of concept analysis, argued that confusion and ambiguity could arise when general uses of a term were combined. Uses of this word generally implied showing the way and making actions happen, guiding, controlling, and directing

2.4 Selecting an appropriate realm for data collection

A literature search of scientific journals was conducted to find material containing the following keywords associated with midwifery care in their titles and abstracts: midwife led, midwifery led, midwifery. Given its context and sphere of operation, the databases of Medline, Embase, Cinahl, were searched and results were subsequently combined. Figure 2.1 illustrates the search strategy. The results were limited to those published in the English language with human subjects. The combined results for the 3 databases yielded 285 results which, once duplicates

were accounted for reduced this number to 184. Thus, 184 abstracts were examined.

The volume of results was testament to the fact that midwifery care and its influence and contribution to childbirth have been of interest to researchers and commentators over a significant period of time. No time limits were applied in anticipation that the term 'midwifery led care' was a relatively new descriptor of practice. The results spanned the years from 1993 to 2013. Full texts were not available by usual means for certain publications (e.g., Essentially Midirs, World of Irish Nursing and Midwifery, The Queensland Nurse). This led to a further reduction of 28 articles. In addition, 80 articles were considered irrelevant on the basis of their abstracts (e.g., women centred approach to undiagnosed breech, action research to develop research skills, midwifery training for post-natal depression screening). Reviews of studies rather than the study itself where the full text had already been obtained were also excluded as it was felt they would add nothing new to the analysis, thus, a further 9 of the abstracts were rejected. Thirty-two full text articles were obtained, of these, 16 included enough detail about underpinning aspects of midwifery led care for them to be included in the analysis. Hand searching of additional literature known to have relevance also took place. Thus, a qualitative study by Guiver (2004), Maternity Matters (DH, 2007); Midwifery 2020: Delivering expectations (DH, 2010), The Birthplace cohort study (Hollowell, 2010) were accessed and each contained sufficient comment about characteristics of midwifery led care to warrant their use.

The historical development of the UK maternity service and midwifery care discussed above suggests how significant reviews such as the Winterton Report (Department of Health, 1992) and the Cumberledge Report (1993) were in establishing the primacy of midwives as carers for the majority of women during their childbirth journeys. It is likely, therefore, that the appearance of 'midwifery led care' around the same period reflects this. History also indicates that midwifery led care was a reality much earlier on in the last century. For example, it has been

suggested that a ‘heyday’ of midwifery existed prior to the creation of the National Health Service in 1948 (Robinson and Thomson, 1991).

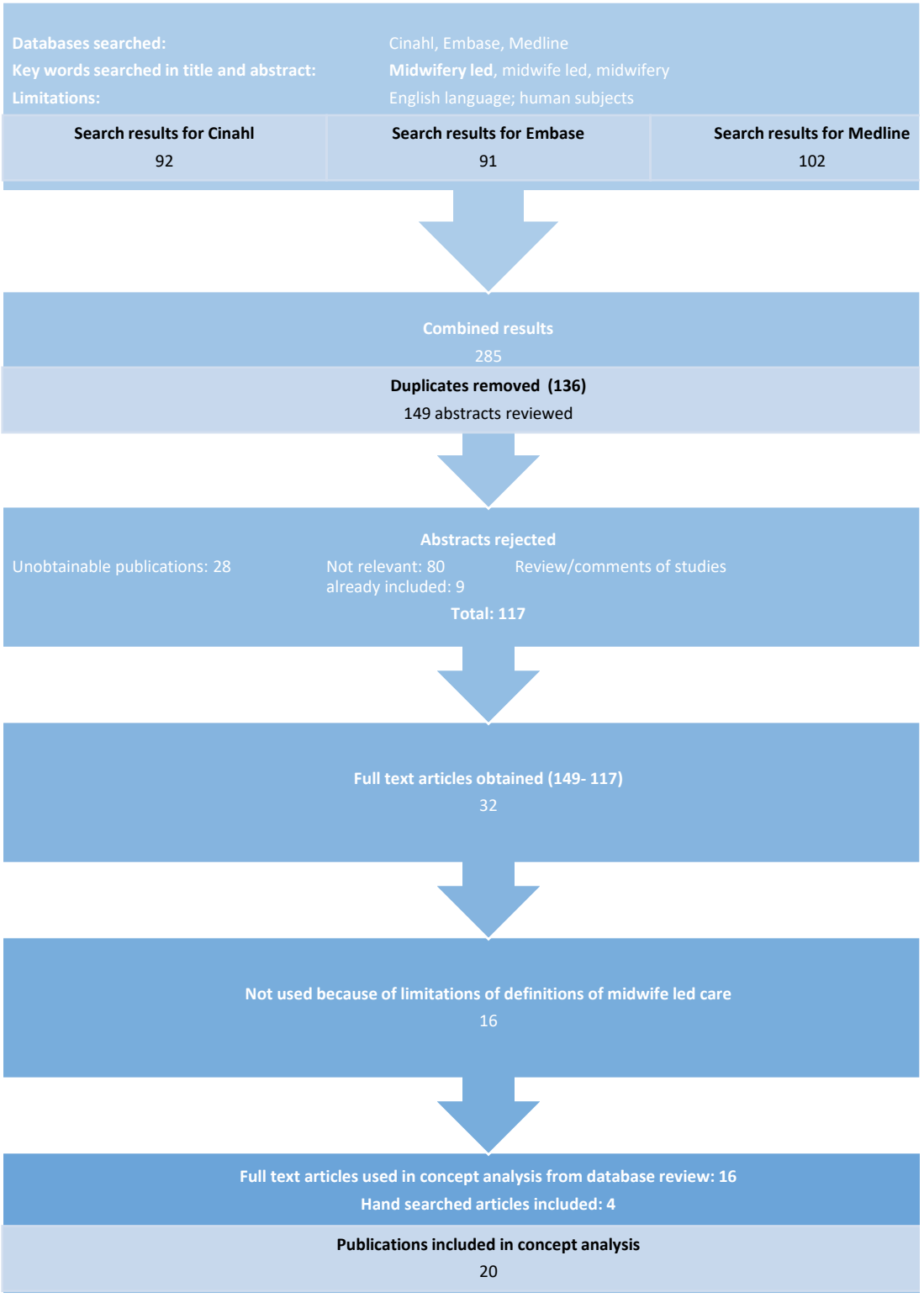

Figure 2-1 Search Strategy

The search results were scrutinised with the purpose of identifying defining attributes of the concept of midwifery led care. The time frame of included articles ranged from 1995 to 2011 with literature derived from the UK, Italy, Australia, the Republic of Ireland, Belgium and the Netherlands, China, and the United States. Reviews such as Sandall et al. (2016) and Walsh and Devane (2012) included reviews from additional countries. Health systems in some of these countries clearly differ from the UK picture in terms of the organisation of maternity care. Sandall et al. (2016), offered descriptions of alternatives to midwifery led care such as obstetrician provided care, common in North America, or care provided by a family doctor, or care that is shared between professionals. The object of this analysis was to uncover the most frequently occurring characteristics (Walker and Avant, 2011) of midwifery led care making it distinctive from other models, and in so doing identifying the particular aspects that contribute to the ethos of this model. Rodgers (1989) refers to the need for a systematically assembled sample of items from a range of sources to add to the rigour of the analysis. A summary of literature reviewed is included as Appendix 1.

2.4.1 Identification of defining attributes of midwifery led care

Defining attributes were compiled once full text copies of search results were examined thoroughly and emerged by synthesising concepts which were considered to be closely related to a particular overarching idea. The attributes thus defined were the result of an interpretative process of extracting themes that emerged with regularity during the literature review and amalgamating them with those that were similar. Different interpretations are possible, therefore, and this fact represents a limitation of the analysis.

The defining attributes are outlined as follows.

- The midwife is the lead professional and acts as an autonomous practitioner
- Midwifery led care is associated with a particular ethos: the belief that childbirth is a normal life process. Midwifery led care encompasses a belief in women to give birth physiologically. Furthermore, midwifery led care involves promoting normality and taking account of women as individuals
- Midwifery led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models (abbreviated in Figure 1 to 'supporting and trusting relationships')
- Midwifery led care is women centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers (abbreviated in Figure 2.2 to 'women focussed, individualised, women as final decision makers').

The formative, developmental process of arriving at the defining attributes is illustrated in Figure 2-2.

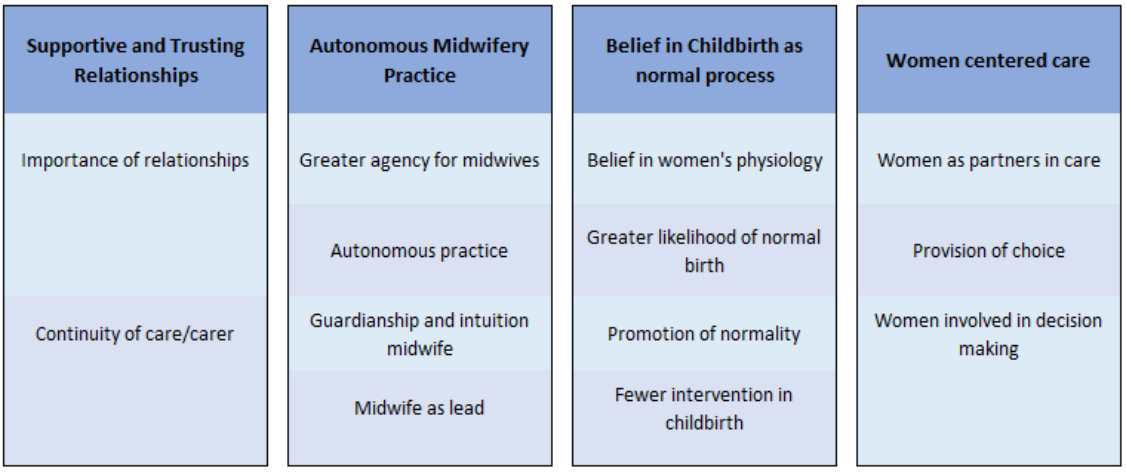

Figure 2-2 Development of defining attributes of midwifery led care

2.5 Discussion

There was a high level of congruence about what constitutes midwifery led care, and the reviewed literature demonstrated an overriding connection between midwifery led care and three particular characteristics that occurred frequently, namely, autonomous midwifery practice, supportive relationships and continuity of care or carer, and the incidence of normal/physiological birth (Figure 2.2). In the background to the Cochrane systematic review of midwifery led care, Sandall et al. (2016) observed that midwifery practice was underpinned by the idea of the inherent normality of childbirth and minimal interventions, the importance of continuity of care, and an individualised service. This paper also referred to midwifery led care as consisting of midwives being the lead professional involved in a woman's care from the initial encounter to the postnatal period. Specific interventions noted by the review were antenatal hospitalisation, and for the intrapartum period, the use of regional analgesia, episiotomy, and instrumental delivery.

In their investigation of care during childbirth in the Netherlands and Belgium, Christiaens and Bracke (2011) noted that the ethos of 'childbirth as a normal life process' led to fewer interventions and a greater incidence of homebirth. This was linked with a predominantly midwifery led and women centred service in comparison with that offered in Belgium. These features were echoed in a Chinese study which examined midwives views of a proposed midwifery led unit. In this study, midwives believed this arrangement of maternity service was associated with fewer interventions, and enhanced normal birth outcomes, and led to a re-emphasis of the principle of women-centredness (Cheung, Mander et al., 2011). Nijagal and Wice (2012) reported on the development of the midwifery led services in Marin County in the United States. The provision of maternity services had been organised historically around a physician led model for insured women. Uninsured

women were obliged to travel to neighbouring counties where the Medicaid[4] programme was more readily accepted. Expansion of midwifery led care was associated with low rates of 'overused' practices such as caesarean birth, induction of labour, and epidural analgesia.

The Department of Health (2007), Williams, Lago et al (2010), Barnes (2010), Murphy (2012), were among those that identified the importance of continuity of care or carer as an inherent feature of midwifery led care. Sandall et al. (2016) had discussed the complexities of continuity, and pointed to the differences in arrangements that exist under this umbrella term. Thus, the caseload midwifery model is regarded as offering a greater opportunity for women to receive care throughout the childbirth continuum, including the intrapartum period, from one midwife and their practice partner. Caseload midwifery is considered to be a way of enhancing relationships between women and midwives, with supportive relationships in themselves being connected with midwifery led care (DH, 2007; Williams and Lago et al, 2010; MacLellan, 2011; Murphy, 2012). This contrasts with team midwifery, where a group of midwives may have responsibility for providing maternity services to a defined group of women. Looking at the foundations of midwifery led care that facilitate normal birth, Guiver (2004) described a situation where midwives possessed skills to work with women, understanding their individual needs and the significance of the birth environment. Guiver (2004) considered that a fundamental dichotomy of knowledge existed in the realms of maternity care: midwifery and holistic versus obstetric; intuitive versus scientific and rationale. Her analysis of midwifery led care identified a multifaceted picture: facilitating birth without intervention and knowing when to intervene; responding to individual women's needs and constructing practice accordingly; taking care not

[4] Medicaid is a Federal and state programme in the United States that assists with the costs of health treatments for people with limited incomes and resources.

to disturb the birthing environment. Her picture was one of the midwifery expertise which contributed to collaboration between midwives and women. It had overtones of the importance of autonomy highlighted by Walsh and Devane (2012), who conducted a metasynthesis of findings of 11 studies of midwifery led care. The literature review also identified attributes of with midwifery led care that were associated with both midwifery practice (continuity, fewer interventions) and the underlying philosophy of care that shapes practice (belief in normality). These different facets were used to construct the model case for the concept analysis.

Having outlined the defining attributes of midwifery led care, the next task, following Rodgers (1989) was to identify its references i.e., the antecedents and consequences. Walker and Avant describe antecedents as being incidences that would have preceded the concept in order for it to be possible, and consequences as events that arose as a result of the concept. The antecedents and consequences are illustrated in Table 2.3 and Table 2.4. The model case is an example that includes all of the defining attributes of midwifery led care. It encompasses the ethos of this model, and is outlined in Table 2.5.

Antecedents of the concept
Professional registration of midwives and legal recognition. Development of sphere of practice. Contributory factors are:
. The 1902 Midwives Act and the beginning of registration for midwives
. Historical consolidation of midwifery practice e.g. from independent practitioners or local authority employees to salaried practitioners working for charities, nursing associations or hospital maternity services by the 1930s
. Creation of the National Health Service (NHS) in 1948 and a national maternity service with midwifery
. Emergence of technological advances and medicalisation of childbirth in the latter half of the last century, and advocacy of increased hospital confinement rates
. Winterton report (House of Commons, 1992) and Cumberledge Report (DH, 1993) advocating midwifery led care for low risk women and collaboration between professionals
. Government policy, Maternity Matters (DH, 2007) and further endorsement of the suitability of midwifery led care for pregnant women at low risk of adverse outcomes
. Maternity service where autonomous midwifery practice is recognised

Table 2-3 Antecedents of midwifery led care

Consequences of the concept
Professional registration of midwives and legal recognition. Development of sphere of practice. Contributory factors are:
The literature review has identified particular consequences of the concept:
Continuity of care/carer (Hatem et al, 2009)
Fewer interventions in childbirth (Meredith 2012)
These are also defining attributes of the concept
Consequences are also for organisation of maternity services into midwifery led models of care , with midwives leading care for low risk women, and being co-ordinators of care for women with identified risks (DH, 2007, Midwifery 2020: 2010)

Table 2-4 Consequences of midwifery led care

Model case

Madinah is a community midwife doing a home visit for a booking[5] appointment. Madinah is a case holding midwife working in a small team of six midwives. After discussions with Mariamme about her previous obstetric and medical history she assessed her as being at low risk of developing complications. She talked with Mariamme about the care she could provide during her pregnancy, including continuity during the antenatal and post-natal periods and attendance by either herself or her midwife partner at the birth of Mariamme's baby. Mariamme agreed with this plan and also agreed to have two routine ultrasound scan appointments, at the antenatal clinic of the local hospital. She requested that some of her care take place at home as she had two other children under the age of five, and did not drive. Madinah explained that she would make every effort to facilitate this.

Because she was 'low risk' Madinah explained that there was no clinical reason for Mariamme to see an obstetrician during her pregnancy unless a complication arose. Madinah also explained that Mariamme's choices of where to give birth: either at home or in the alongside midwifery led birthing unit (MLBU) or in the consultant led maternity unit. She explained what each of the hospital settings provided, and that Mariamme could make the decision of where to give birth at any point of her pregnancy including when she was in labour.

Mariamme went on to have a straightforward pregnancy. When she went into spontaneous labour she was visited by Madinah, and decided that she wanted to give birth in the alongside midwifery led birthing unit. Madinah made the arrangements for her admission and met her at the unit when Mariamme was in established labour.

Madinah provided care to Mariamme throughout her birth. She sought consent from Mariamme for maternal observations of blood pressure, temperature pulse and respirations, as well as an abdominal palpation. Madinah did not feel that a vaginal examination was indicated at this point as Mariamme was contracting well and in any case, Mariamme was keen to avoid one. Mariamme wanted to have her partner and mother present and Madinah welcomed them and made sure they had access to drinks. An hour and a half after being admitted Mariamme's labour began to stall and contractions became less frequent. Madinah suggested a vaginal examination which Mariamme accepted. Her cervix was six centimetres dilated with intact membranes. After 45 minutes of reduced frequency of contractions and following discussions between Madinah and Mariamme, Mariamme decided she needed to have something to eat and drink and a short nap. She woke after 15 minutes and went for a walk around the hospital gardens with her birth supporters. When she returned half an hour later her contractions had returned and she had a normal birth within the next hour. When Mariamme was discharged home Madinah and her midwife partner provided postnatal care and discharged her after two weeks.

Table 2-5 The Model Case

[5] The booking appointment is the consultation women have with their midwife to 'book' them for maternity care.

This example of a model case takes full account of the defining attributes of midwifery led care identified above. This is what Avant and Walker (2011) refer to as a 'paradigmatic example' or a 'pure exemplar' (p.163). In Table 2.6 below, the individual attributes are mapped with features of the model case. It has been constructed to include few(er) interventions, continuity of carer within a case holding model, promotion of normal birth, women centred and individualised care, and autonomous practice.

The midwife is the lead professional and acts autonomously, in conjunction with the woman' The case loading model is an example of midwives acting as lead professional, considering the individual circumstances and choices of women, as indicated by other attributes of midwifery led care. The decisions made during the pregnancy were taken by both the midwife and the woman. Autonomy was demonstrated by the midwife having the authority and control necessary to facilitate choices taken by Madinah, in addition the idea of agency of woman and midwife is apparent. Agency is considered to be a component of autonomy.
Midwifery led care is associated with a particular ethos: the belief that childbirth is a normal life process. Midwifery led care encompasses a belief in women to give birth physiologically. Furthermore, midwifery led care involves promoting normality and taking account of women as individuals The model of care Mariamme was assigned to has as its premise that childbirth is a normal process. This was reflected particularly during labour where there was encouragement for and belief in Mariamme to give birth without the need for intervention.
Midwifery led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models The care provided to Mariamme is organised around a caseload model and this ensures continuity of carer. Mariamme and Madinah get to know each other during the pregnancy and this facilitates the development of a relationship between them.
Midwifery led care is women centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers 'Midwifery led care is associated with fewer interventions in childbirth' The model case demonstrates the attribute of women centredness in the planning care around Mariamme's needs and choices in the antenatal and labour period e.g., facilitating appointments at home, offering and ensuring genuine choice in the decision about place of birth. Regard for individual needs is demonstrated in the model case primarily by providing care that reflects what was suitable for Mariamme. When her labour stalled, a strategy of eating, drinking and mobilisation was used to stimulate contractions. There was a minimal amount of vaginal examinations

Table 2-6 Mapping attributes with features of the model case

In the process of concept analysis, related cases were constructed to determine concepts similar to but different in important ways from those expressed in the

model case (Walker and Avant, 2011). The model case provided an illustration of midwifery led care, incorporating the defining attributes assembled from literature review. The related case enabled a 'constellation' of surrounding ideas of the topic to be identified (Walker and Avant, 2011). An example or a related case is summarised in **Error! Reference source not found.** below.

Related case
Sarah was a community midwife who held her clinics in a local GP surgery. She worked in a team of eight midwives. During one of her clinics she had a consultation with Helena, a multiparous woman. Helena had had two previous spontaneous vaginal births. A pregnancy consultation (booking) was undertaken. After discussing her previous history and experiences Sarah assessed Helena as being at low risk of developing any complications. She discussed with Helena that all her appointments would take place at the surgery during the antenatal period, apart from two ultrasound scans that were provided by the local hospital, and a consultant appointment to check that all was well, at around thirty six weeks. Helena enquired whether any home visits were possible, as she did not have use of a car, lived some distance from the surgery and had young children. Sarah was very apologetic when she explained that this was not possible as it was the policy of the hospital to insist women's care took place at the surgery, where all IT equipment was available. Sarah explained that for her appointments at the surgery she would be able to provide continuity as her named midwife, however, should she choose to give birth in a hospital it would be a hospital midwife who would attend her. Helena went on to have a straightforward pregnancy. When she went into spontaneous labour, she decided that she wanted to give birth in the local consultant led unit. She arranged admission herself to the labour ward, using the contact details that she had been given by Sarah. Her partner and mother accompanied her. She was contracting strongly. She was looked after by Gina, an experienced midwife who worked on the unit. After the initial checks, Gina suggested that Helena have a vaginal examination to check that she was in established labour. Helena consented and her cervix was 8 cms dilated with intact membranes. After an hour Helena's labour began to stall and her contractions became less frequent. The labour ward co-ordinating midwife happened to make an enquiry about Helena's progress and on discovering the situation suggested an artificial rupture of membranes (ARM), this action is considered to augment contractions and potentially shorten the labour. However, the suggestion was also based on the shortage of beds on the labour ward, and the need for women to give birth as soon as possible in order to avoid having to close the unit to further admissions. This 'management' aspect of the suggestion was not discussed with Helena. Gina discussed the ARM with Helena, who was reluctant for this to happen. Gina then suggested Helena have something to eat and drink and go for a short walk. Helena went off the ward and returned 20 minutes labour wanting to push. Her baby was born normally in the next 15 minutes and all was well. After being discharged on the same day, she was looked after in the post-natal period by Sarah and 2 other members of her team.

Table 2-7 The related case

In both the model and related case women are cared for by midwives and thus midwives act as lead professionals. Walsh and Devane (2012) suggested that midwifery led care has, over time, evolved to imply autonomous care by midwives of women considered to be at low risk of needing interventions during the

childbirth continuum. Both cases attest to the autonomy of midwives but a stronger case can be made for its presence within the model case. For example, midwife Madinah was able to offer antenatal home visits whereas midwife Sarah was not.

In the related case, the components of continuity of care were offered, however, this contrasted with the continuity of carer model intrinsic to the model case where relational continuity features. To some extent care organised is around the individual but this is not as apparent as in the model exemplar case. There are attempts to promote normality, but more interventions are offered.

2.6 Conclusion

This concept analysis sought to identify the defining attributes of midwifery led care, as recognised by a relevant body of literature. The idea of midwives being identified as the lead professional in the maternity services for women who are considered to be at low risk of developing complications is embedded in UK maternity policy (DH, 2007; NHS England, 2016) and current thinking about the future of midwifery practice. Rising levels of interventions in maternity care, partially associated with advances in technology such as electronic fetal monitoring and obstetric ultrasound, have developed alongside the recognition of the benefits of normal childbirth related to midwifery led care.

Uncovering the defining attributes of midwifery led care, its antecedents and consequences leads to questions about how closely midwifery practice reflects and embodies these attributes. Given the positive analysis of midwifery led care in terms of satisfaction for women and midwives, quality of care provided, reduced interventions associated with good outcomes, a further question relates to how midwives working in midwifery led clinical setting enact these defining attributes in their practice. This question formed the basis of the current research. How it has

been addressed is outlined in subsequent chapters. In Chapter 3, the defining attributes of midwifery led care are further developed through literature review.

Chapter 3 Literature review of defining attributes

3.1 Introduction to the review

The concept analysis of Chapter 2 established that midwifery led care is associated with women centred and individualised care, a lack of routine interventions, a concern with women being involved in decision making, continuity of care, an ethos of partnership between midwives and women, professional midwifery autonomy, and belief in normal birth. This literature review looked at evidence relating to the these and other components of the defining attributes in order to expand their meanings and knowledge of how they were experienced in practice. Electronic databases used in the search strategy ranged from health to social sciences so that different angles could be explored, i.e., Medline, EMBASE, CINAHL, BNI, PsycINFO. Further searches took place of reference lists of literature accessed, and reports known to the researcher to be relevant, such as the Maternity Review: Better Births (NHS England, 2016), and the Cochrane Review of Midwife led versus other models of care (Sandall et al., 2016).

A detailed search strategy was developed for each defining attribute theme resulting in a high volume of results. Date restrictions were imposed so that only literature after 1992 was accessed, as 1992 and 1993 saw the publications of the Winterton report (House of Commons, 1992) and the government response, Changing Childbirth (Department of Health, 1993). This period heralded the emergence of midwifery led care as a principle of the UK maternity services. Literature based on human experience, and published in English was considered. The exclusion criteria were literature not focussing on the experience of midwives (e.g., student focussed or examining other professionals practice) brief

commentaries or editorials, or results that did not include an abstract for further determination of relevance.

Abstracts of search results were examined, with the full text being accessed if they appeared to be relevant. Some of the literature appeared in search results of more than one defining attribute theme, demonstrating interrelationships. As a percentage of the total amount of literature looked at there were relatively few that specifically addressed how midwives enacted the attributes of midlife led care within their sphere of practice, particularly with respect to the care of low risk women.

The intention behind the search strategy adopted for this work was to identify accessible studies which explored and reported on the meanings of different attributes of midwifery led care and how they were enacted in professional settings. The review included literature which described and analysed the defining attributes of midwifery led care with a separate search being carried out for each. Literature based on human experience, and published in English was considered. The exclusion criteria were literature not focussing on the experience of midwives (e.g., student focussed or examining other professionals practice) brief commentaries or editorials, or results that did not include an abstract for further determination of relevance. The original literature review was carried out in 2013, before the period of data collection. It has since been updated to include data published from 2013 to 2020 which contained new evidence. The review critically examines the literature for each of the defining attributes in turn.

3.2 First defining attribute

The midwife is the lead professional and acts as an autonomous practitioner

Keywords searched: midwifery, midwifery led, professional autonomy and autonomy using combinations of keywords in titles and abstracts and MeSH

headings associated with these terms. Databases searched: Cinahl, Medline, BNI, PsycInfo.

The 2013 search yielded 182 results after duplicates were filtered. Abstracts were present for all but 26 of the results and these abstracts were examined for quality and relevance; papers were not included, therefore, if no abstract was present. Studies focussing on students, or professional groups other than midwives, journal comments, letters, and editorials, and papers with no abstract present were excluded (74 results). For 83 articles full texts were not available via the usual retrieval process. This comprised a large number of studies whose findings may have contributed to the review and represents a potential limitation of the review. The full texts of 25 papers were retrieved and examined. This resulted in a further 12 being rejected due to not directly addressing, or not mentioning the issue of autonomy within midwifery. Fourteen articles were included in the review covering a period from 1998 to 2013. In addition, a hand search for global definitions of midwifery practice revealed the International Confederation of Midwives' position statement. The revised search in 2020 resulted in one document of interest, and one updated review. The search strategy is illustrated in **Error! Reference source not found.**.

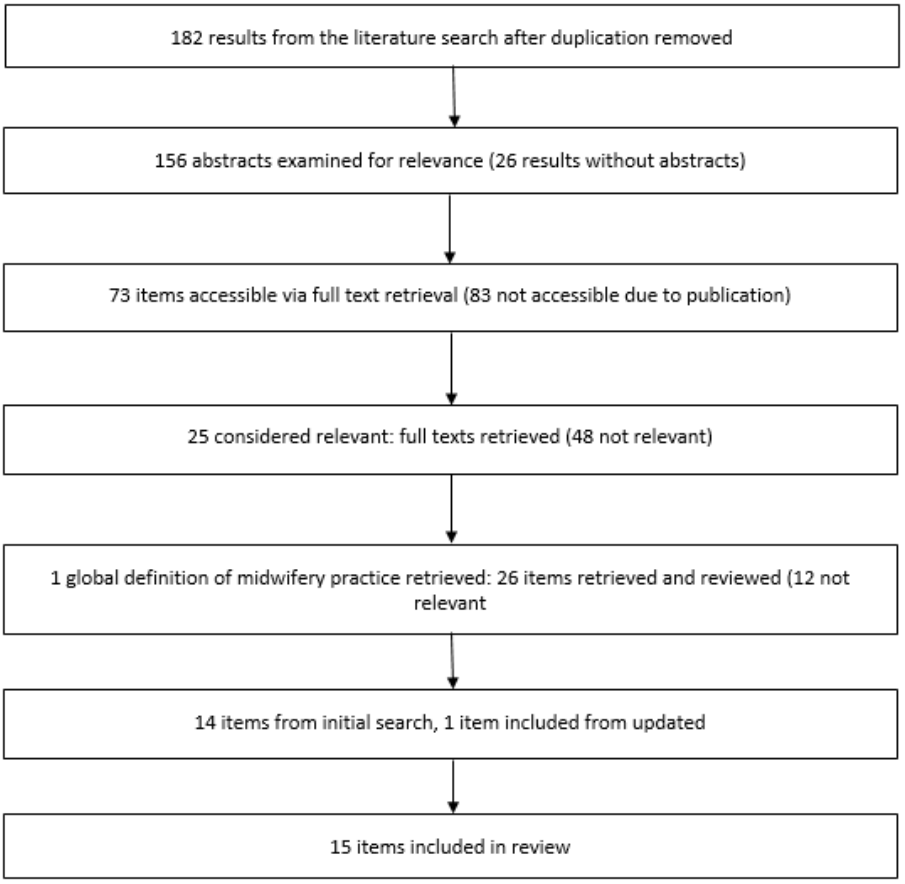

Figure 3-1 Search strategy and results first defining attribute

3.2.1 Autonomy

Autonomy and autonomous practice are embedded in the scope of midwifery practice and are associated with concepts such as authenticity, agency, and responsibility (Downe and O'Connell, 2009; Devane and Walsh, 2012). In its 'International definition of the midwife' the International Confederation of Midwives (ICM) (2010 and 2017) recognised midwives as being accountable professionals providing necessary care and support to childbearing women and their babies, during the antenatal, intrapartum, and postnatal period, on their

'...own responsibility'. The World Health Organisation (WHO) endorses this view and it is referred to by the RCM, an ICM member organisation. Standards for midwifery practice set out by the Nursing and Midwifery Council (NMC), the professional regulator, mandate that at the point of qualification midwives should '…be accountable and autonomous as the lead professional for the midwifery care and support of women and newborn infants throughout the whole continuum of care' (NMC, 2019, p 14).

The literature can be organised around two themes: definitions and conditions for autonomy and limits to autonomy. As for all of the defining attributes, the categories are developed by a particular interpretation of the literature and it is acknowledged that different interpretations are possible. The contents of themes are not mutually exclusive and there is a good degree of overlap.

3.2.1.1 Attributes and conditions of autonomy

Several studies referred to the centrality of the concept of autonomy to the scope of midwifery. Cotton (2008) in her discussion about the reality of midwifery practice suggested that the health policy initiatives that were prominent at the time of her writing, such as 'The new NHS: modern and dependable' (DOH, 1997) facilitated midwifery autonomy by proposing increased roles for midwives in setting standards of care. This understanding is echoed in more recent literature (ICM, 2011).

In the context of midwifery practice, autonomy is associated with terms such as decision making capacity, power, and authority (Cotton, 2008), empowerment (Hermanson, 2011), high levels of satisfaction (Collins et al., 2010), and control and recognition of professional worth (Matthews et al, 2006). Pollard (2003) conducted a small scale qualitative enquiry with the objective of uncovering what midwives understood about autonomy and whether they considered themselves and their colleagues to be autonomous. Prior to undertaking her study, she completed a

concept analysis of autonomy and the results were used to guide the study's interview process.

The framework developed from the concept analysis uncovered associated characteristics, antecedents, and consequences of autonomy. For example, autonomy brought with it the ability to 'determine the sphere of activity under one's control', to make choices and take decisions relating to this sphere, to take responsibility for the actions taken, and to have the recognition by others involved in the area of interest (Pollard, 2003, p 115). The midwives in the study viewed power exercised over the maternity service by medical professionals, attitudes of senior midwives if decisions were taken when women's interests conflicted with those of the service, and the lack of distinction between midwives and nurses, as barriers to the exercising of their autonomy.

Matthews et al.'s (2006) findings from a study of conditions that facilitate the empowerment of midwifery complement those highlighted by Pollard (2003) in that the factors most associated with empowerment were control, support, recognition, and skills. The study consisted of a cross sectional, descriptive national survey of Irish midwives. Factor analysis was used to assess the data obtained from the Understanding of Empowerment Scale incorporated into the questionnaire. The factors were similar to those identified by Pollard (2003). Thus, 'control', as a factor of empowerment referred to how midwifery practice was managed and resources mobilised, 'recognition' included medical personnel's regard for midwifery practice and how autonomous midwives could be in acting as advocates for women and the choices and decisions they make. Matthews et al. (2006) contended that though midwives believed in their own autonomy, in reality they were controlled by the healthcare system and the dominant medical paradigm's hold on their sphere of practice. These doubts about midwifery autonomy were juxtaposed with national and international calls for empowerment (An Bord Altranais, 2001; International Confederation of Midwives (ICM), 2010).

In their study of work engagement, Freeney and Fellenz (2013) applied the job demands- resources model to midwifery practice in two large maternity units in Ireland. Work engagement was defined as 'a persistent, positive, affective-motivational state of fulfilment in employees characterised by energy, dedication and absorption' (p 1428). The premise of the job demands resources model was that all occupations have work demands, i.e., aspects of the job requiring effort, and work resources or components of the job that help to manage demands and enable goal achievements. Success in the work environment depended on work resources exceeding work demands. They identified job resources as being autonomy, feedback from performance, task significance and social and supervisor support. Though autonomy alone was not sufficient for motivating midwives and enabling them to derive meaning from their work, it was an important prerequisite for work engagement.

3.2.1.2 Limits to autonomy

Though autonomous practice is seen as an inherent feature of midwifery (ICM, 2011), the reality of midwifery not holding to this ideal was debated in the relevant literature (Fleming, 1998; Hunter, 2005; Parsons and Griffiths, 2007; Cotton, 2008; Lindstrom, 2008; O'Connell, 2009; Hermansson, 2011). The existence of midwifery autonomy was refuted by Fleming in 1998 in an exploration of practice in Scotland and New Zealand. She provided a historical account of midwifery in both countries, which took state registration as its starting point. She argued that medical dominance of childbirth has led to choice, power and the ability to self-govern and self-regulate been curtailed, particularly on a collective level. Hunter (2005) explored how midwives managed emotion in their working environments, by conducting focus groups with student and registered midwives. She discovered that disharmony among work colleagues was a key source of emotion work. This was particularly apparent in relationships between junior and senior midwives. She

noted how senior midwives defined the limits of what acceptable midwifery practice was. Knowledge and understanding of these practices were conveyed through unwritten rules and sanctions. Furthermore, senior midwives were more likely to operate 'with institution' than 'with woman' than other midwives. Such divisions led to difficult relationships, and forms of social control by senior midwives were thought to impinge individual autonomy and independent working.

A metasynthesis of midwives' experiences of hospital practice in publicly funded settings sought to determine what midwives perceived about hospital midwifery (O'Connell and Downe, 2009). This work focussed particularly on labour ward practices with respect to midwifery guardianship of normal childbirth in circumstances of risk aversion and consumerism. Fourteen studies were selected for analysis. All reported from high resource countries. The three themes identified were power and control, compliance with cultural norms, and attempting to normalise birth. The authors commented on the dominance of the medical model of care portrayed in the studies, which prioritised obstetric thinking and sanctioned obstetric control. Within the 'power and control' theme, midwives lacked autonomy in using skills that could reduce interventions. In complying with cultural norms, midwives acquiesced in practising for the benefit of the needs of the unit and meeting its standards rather than directing care to individual women's needs. Real or authentic midwifery, in contrast, was enacted where women were protected from excessive intervention. The metasynthesis concluded that though midwives were assumed to be autonomous decision makers capable of directing care towards individual circumstances, the reality of maternity care refuted that picture of midwifery. Metasynthesis was also used by Walsh and Devane (2012) to examine why low risk women experienced fewer interventions when receiving midwife led care. The metasynthesis included 11 articles which reported on eight different studies. Three themes were identified: 'relationally mediated benefits for women', difficult relations between birth centres and associated consultant led units, and the positive effect of midwifery led units on midwifery agency. Through

the results of this metasynthesis, Walsh and Devane (2012) argued that midwives were more likely to attain autonomy in midwifery led birth centre settings.

This review has found that autonomy is an assumed and desired characteristic of midwifery practice, yet prerequisites necessary for autonomy were not always present. There is some evidence this being particularly true outside of midwifery led settings.

3.3 Second defining attribute

Midwifery led care is associated with a particular ethos: the belief that childbirth is a normal life process. Midwifery led care encompasses a belief in women to give birth physiologically. Furthermore, midwifery led care involves promoting normality and taking account of women as individuals.

Keywords searched: midwifery, midwifery led, health, natural childbirth, combinations of key words in titles and abstracts, and MeSH headings associated with these terms were used. Databases searched: Medline, Embase, Cinahl, Medline, BNI, PsycInfo.

The search strategy is illustrated in Figure 3.2 **Error! Reference source not found.**.

The 2013 search resulted in 106 papers after duplicates were filtered. Papers were then excluded where abstracts were not included, lacking lacked relevance, or where access full text was not possible. 10 studies were retrieved and full texts perused. A further 2 were rejected after this process Eight articles were considered to contain sufficient discussion and explanation of how the concept of normality is pertinent to midwifery led care. Articles were published between 2000 and 2011.The revised search in 2020 did not identify new understandings of the themes.; an updated Cochrane review (Sandall et al., 2016) was added. The search strategy is illustrated in **Error! Reference source not found.** below.

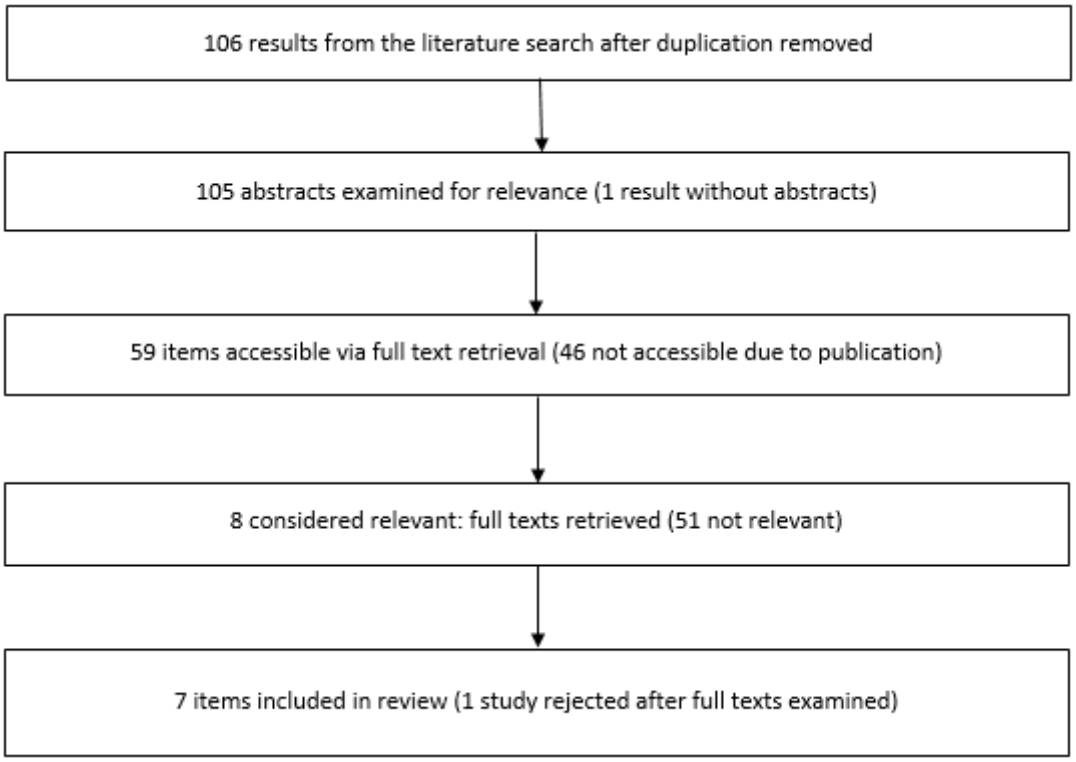

Figure 3-2 Search strategy and results second defining attribute

In the literature examined, the proposition that pregnancy, labour, and birth were normal life processes was axiomatic to the midwifery philosophy of care (Davis, 2010; Russell, 2007; Anderson, 2003; Kennedy, 2000). The Cochrane systematic review of comparison of midwife led versus other models (Sandall et al., 2013) found that spontaneous vaginal birth was more likely to occur with midwifery led models. The updated review reported the same finding (Sandall, 2016). The International 'Definition of a Midwife' recognised a unique role for midwives in global maternal health (ICM. 2011). An important concept in the definition was the view of pregnancy being a 'normal life event'. Whilst this position was confirmed, the literature indicated that challenges existed to midwifery claims of facilitating normal birth, and critical analyses of midwifery practice suggested that midwives may actually participate in the medicalisation of childbirth. The review of literature

relating to this attribute of midwifery led care identified two contrasting themes: midwifery care supporting the process of birth, and midwives as barriers to normality.

3.3.1 Midwifery care supporting the process of birth

The idea that midwives contributed a unique quality of care in labour resonated through several studies. Kennedy (2000) investigated components of care that could be characterised as 'exemplary midwifery practice' in her Delphi study of American midwives, which sought to clarify the process of midwifery processes of care. Expert midwives were surveyed on multiple occasions. Through exchanges between researcher and participants a model was formulated which incorporated dimensions of care thought to be present. The dimensions painted a picture of what happened in practice. Thus, 'therapeutics' encompassed how midwives supported normal birth, ensured individualised care, refrained from hurrying the process, and were judicious with interventions. This dimension also featured attention to detail of the labour and exceptional clinical skills. Attention to detail involved thoroughness in assessing women in order to assure continued normality rather than searching for pathology. 'Caring' represented another of the model's dimension. Women were regarded as individuals, encouraged, and supported. The final dimension encompassed regard for midwifery as a profession through reviewing practice and continuously updating knowledge.

Through these conclusions Kennedy's (2000) attempted to qualify how midwifery expertise was enacted and similar aims are addressed in later studies (Guiver, 2004; Davis, 2010). Whereas Kennedy (2000) looked at dimensions of care associated with expertise, Guiver (2004) used thematic analysis and modified grounded theory to explore the epistemological foundations of midwifery led care that contributed to normal birth. The study, based in the UK, found evidence of a multifaceted knowledge base, a significant feature of which was that midwives did not separate their professionally derived knowledge with that gained from their interactions

with women. Knowledge was also accumulated by observing women and taking their individual circumstances into account. In this study, midwives' knowledge was expressed in a series of categories. They had knowledge of when to intervene and the appropriateness of inaction; their knowledge of how to deliver care came from experience and clinical judgement. They acknowledged the importance of creating a birth environment that did not disturb the birthing process. They were also committed to the influence of women's personal experiences, as well as physiological processes, on how they progressed in labour. In creating her theory of midwifery knowledge, Guiver (2004) accepted 'obstetric knowledge' as operating in a narrower realm and concerned primarily with pathology. Obstetric knowledge was made use of in midwifery practice, but was not the driving force.

Davis (2010) carried out a concept development of normalcy using descriptions given by a set of US-based midwives operating in freestanding birth centres and hospital settings. Midwives accounts of their labour room practices were used to determine the underlying attributes. They were summarised as: the existence of a psycho- physiological processes that varied along a continuum including the process itself and the outcome; dependence on the woman's unique physiology and life circumstances; and influence of environmental factors. It was thought that midwives' understandings of the attributes of normalcy were reflected in the care they gave. Davis (2010) suggested that knowledge of these descriptors of normalcy, for example, that factors other than physiology might affect a women's progress in labour, enabled midwives in 'contested clinical environments' such as obstetrically managed hospital settings, to advocate for more appropriate care management decisions.

Findings from a grounded theory enquiry assessing midwives' experiences of supporting normal birth in a UK obstetric unit setting give only limited support to this possibility (Russell, 2007). The research participants were labour ward midwives. The findings demonstrated that midwives used a variety of practices to support normal birth. This was despite the labour ward being seen as operating

along hierarchical lines, with obstetricians being the dominant party. The midwives also considered that obstetricians had increased their input into the care of 'normal women' and this was viewed negatively. The hierarchy was occupied by senior co-ordinating midwives, who were positioned below obstetricians but above the ordinary midwives. The category of 'labour ward practices' consisted of descriptions of midwives remaining with women in labour rooms to guard against intervention or the underestimation of cervical dilatation (to 'allow' for a longer second stage of labour). These actions were associated with maintaining clinical autonomy. Pollard's concept analysis discussed above, however, offers a different opinion of autonomy, one where midwives have some control over their sphere of practice and recognition by colleagues (2003), conditions that do not appear to hold in the settings of Russell's study.

3.3.2 Midwives as barriers to normality

Scamell (2011) conducted an ethnographic examination of how midwives comprehended risk in their practice and how this was reflected in conversations with women. In it she described the tension between midwives' responsibility to encourage and promote women's belief in their ability to give birth, and midwives' roles in the comprehensive risk surveillance that features in intrapartum care. Scamell's contention was of disconnect between the representation of midwifery being embedded in promoting normality and what happened in midwives' daily practice. Scamell also suggested that the risk surveillance practices lessened women's self-confidence in a straightforward outcome of labour because they introduced uncertainty about their progress. Midwives operating in all birth settings participated in the research (homebirth, freestanding, collocated and consultant led unit). The effects were partially influenced by the working environment, but to a lesser extent than was expected. Kennedy (2000), Guiver (2004) and Davis (2010) also outlined components of intrapartum midwifery care which were sensitive to different settings. In showing midwives in less favourable light than other studies, Scamell indicated the complexity of midwifery practice.

This review found that midwives expected their practice to be associated with normality, and that they were self-conscious of how their care could lead to women experiencing normal birth. There was also congruence with midwives' and women's perception of quality. The studies reviewed were generally small scale and claims of generalisability were not made.

3.4 Third defining attribute

Midwifery led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models

Keywords searched: midwifery, midwifery led care, continuity of patient care, nurse-patient relations, interpersonal interactions, continuity of care, partnership. Combinations of keywords were used for title and abstracts. A number of these terms are MeSH headings. Databases searched: Medline, Embase, Cinahl, BNI, PsycInfo.

The 2013 search resulted in 144 results after duplicates were removed. 108 of these had abstracts that could be examined for relevance and a as a result 40 were rejected due to publication inaccessibility. Papers were included if they reported on aspects of continuity and partnership with respect to midwifery care, published in English post 1992; 11 fulfilled these conditions. The updated search in 2020 resulted in 6 new papers, being identified as relevant to the thesis. Two documents were added as a result of hand searching: the report of the National Maternity Review (NHS England, 2016) and the updated Cochrane systematic review comparing midwifery continuity with other models of maternity care (Sandall et al., 2016).

Exploration of the reference lists of the included literature also contributed relevant papers to the overall review. The search strategy is illustrated in Figure 3-3.

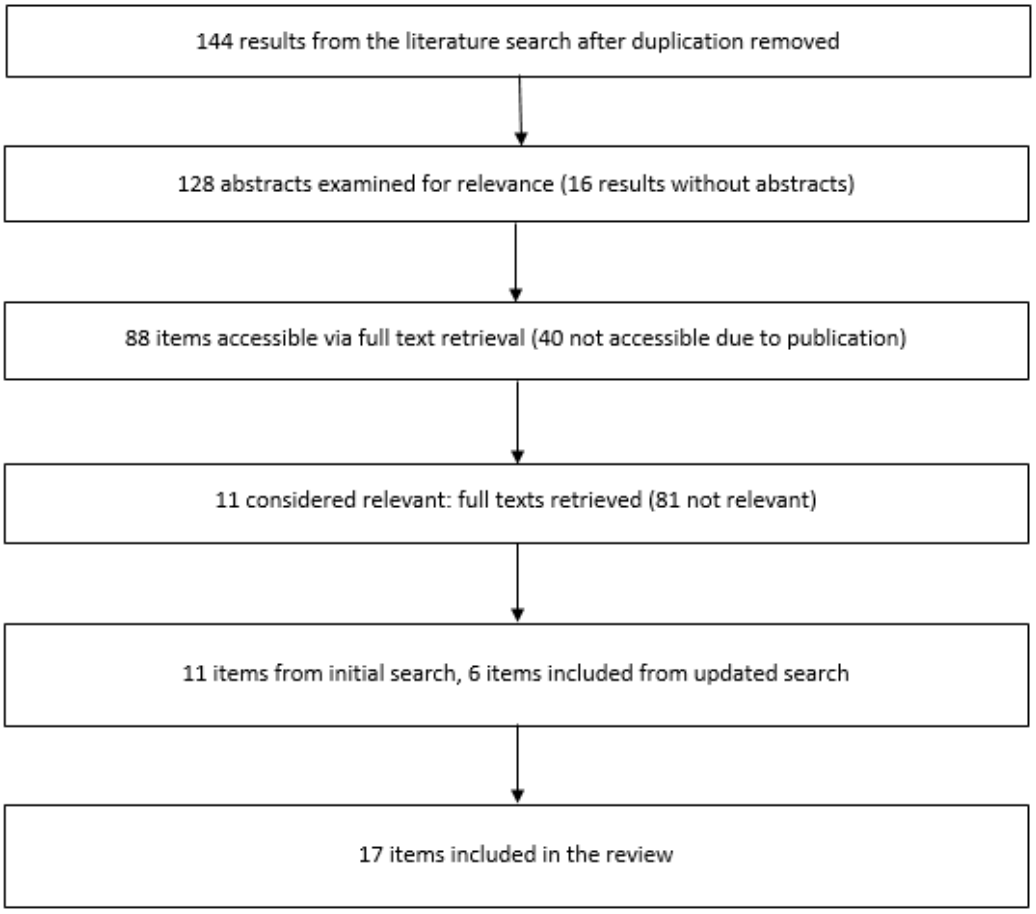

Figure 3-3 Search strategy and results third defining attribute

3.4.1 Continuity of care

It was clear from the literature that authors were preoccupied by the nature and value of relationships between women and midwives and these were explored with respect to both continuity of care and partnership. Different presentations of midwifery continuity were described, and both women's and midwives' views were

subjected to scrutiny. This is unsurprising since both parties participate directly in the relationship. The quality of relationships was cited as being integral to safe care (Hunter et al, 2008) and indeed, the two most notable themes from reviewing this dimension of midwifery led care were the importance of continuity and partnerships, and quality of relationships between midwives and women.

3.4.2 The importance of continuity

The literature concerning continuity was dominated by reviews comparing it with other models of healthcare. Most of the reviews relied on Haggerty et al.'s (2003) definitions of continuity of care. This work discussed the impact of the lack of agreement on definitions of continuity for global healthcare policy. In reviewing and synthesising definitions of continuity from different settings, therefore, Haggerty et al. (2003) were attempting to make it easier to understand and measure its effects. In their review, 'care of an individual patient' and 'care delivered over time' were identified as defining features of continuity. These were present in each of the three expressions of the concept of continuity that Haggerty et al. (2003) identified (informational, managerial, and relational). Informational continuity took place where written or verbal information was shared about a patient over time, between different care providers, and across different care episodes. Thus, information about patients' past histories and preferences could be shared and used to construct individual care. Where managerial continuity existed, several care providers with a shared management plan provided regular, coordinated, and flexibly arranged care. Finally, relational continuity consisted of ongoing therapeutic relationships between an individual patient and one or more providers. Haggerty et al.'s (2003) typology was developed to assist in evaluating the concept of continuity across different disciplines and organisational boundaries in healthcare including maternity services. It is of note that Haggerty et al. (2003) suggested that it was not sufficient to focus on the longevity of a therapeutic relationship without considering the quality of the interpersonal encounters that made up the relationship.

Relational continuity was the label adopted for models of midwifery led care in several studies (Sandall et al., 2016; Page, 2003; Benjamin et al., 2001). Benjamin et al. (2001) constructed a non-randomised clinical trial comparing partnership caseload midwifery care with conventional team midwifery care, at a UK hospital in 2001. In caseload midwifery care, women were assigned a primary and secondary midwife, who worked in partnership with each other. Conventional team midwifery entailed most of the antenatal and postnatal care being delivered by a named community midwife. Provision of labour care was the responsibility of one of the teams' midwives, including the named midwife. The teams were large, consisting of up to 25 midwives. Women were assigned to either the conventional group where they received standard team midwifery care (n=308), or to the experimental caseload group (n=303). Women in each arm of the trial were matched for age, ethnicity, marital status, parity, height, and number of previous pregnancies. Randomisation was not considered feasible as women generally accessed maternity services via a GP where opportunities to randomise to different models of care would not have been available. The primary outcome of the trial was the uptake of epidural analgesia in labour. Secondary outcomes included method of delivery, rate of induction of labour, oxytocin augmentation in labour, and maternal upright positions for birth. The study found that partnership caseload midwifery resulted in fewer incidences of epidural analgesia, and led to greater occurrences of non-interventionist birth, indicated by the secondary outcomes. The study's authors suggested continuity of carer accounted for the results.

Over a decade later, Sandall et al. (2016) completed a systematic review comparing midwifery led continuity systems of care with other models. The review examined data from 15 trials and involving 17 684 women. The trials were conducted from 1989 to 2013, and originating from 4 countries, Australia (8 trials), Canada (1 trial), Ireland (1 trial), and the UK (5 trials). Primary outcomes for the review were regional analgesia, caesarean birth, instrumental vaginal birth, spontaneous vaginal birth, intact perineum, preterm birth, all fetal loss at any gestation, and neonatal death. The defining features of continuity entailed midwives being the lead professionals

for identified groups of women, who then become the 'caseload'. The women were usually assessed as healthy and 'low-risk' throughout pregnancy, labour, and the post-natal period. The review presented options for midwifery led continuity models, which corresponded with those proposed by Benjamin et al. (2001), i.e., 'partnership caseload' and 'conventional team'. Sandall et al.'s (2016) review found that both midwifery led continuity models favoured six of the primary outcomes (less regional analgesia, instrumental delivery, preterm birth, and all fetal loss, and neonatal death, more spontaneous vaginal birth), and made no difference with the remaining two (caesarean birth or intact perineum). Most of the midwifery led continuity models selected for this review consisted of 'team' midwifery. Subgroup analysis of the options of midwifery led continuity found no difference between caseload and team models for the outcomes of caesarean birth, instrumental and spontaneous vaginal birth, intact perineum, preterm birth, all fetal loss, and neonatal death. Because women's satisfaction with midwifery led continuity models was inconsistently measured in the included studies, the review presented a narrative account of this outcome. It found greater levels of satisfaction with midwifery led continuity, compared with other models of care. Sandall et al. (2016) commented on the complexity of midwifery led continuity models. They suggested that the quality and degree of the relationship between woman and midwife, the model of midwifery led care, and philosophy of midwifery care, were factors that could also account for the effects observed by the review. Such factors, however, were considered beyond the scope of the review, and therefore, the practices associated within midwifery led care needed further exploration.

The literature search identified a number of qualitative studies examining the views of midwives and women about continuity of care/carer models and the impact of the midwife–woman partnership (Collins, Fereday, Pincombe et al., 2010; Hunter, 2009; Hunter et al., 2008; Freeman, 2006; Davey, Brown, and Bruinsma, 2005; Fleming, 1998). The studies were conducted over a period from 1998 to 2010 and demonstrated contrasting findings. Fleming (1998) examined what midwives and women believed about the concepts of continuity of care and partnership in New

Zealand nearly ten years after midwives had gained professional independence. She looked at the relationship between 12 independent midwives (working outside the hospital system) and 20 women 'clients' of midwifery services, through a 3-year research project. She concluded that beliefs underpinning midwifery practice were not necessarily aligned with women's beliefs, or expectations. Midwives held particular beliefs about relationships which influenced their concerns about what an effective therapeutic relationship should comprise. They were dedicated to providing support, facilitating choices, and affirming women's agency. They endeavoured to practice with minimum intervention in childbirth processes, even whilst accepting their responsibilities for routine clinical 'checking of pregnancy'. In contrast, it was the knowledge midwives possessed in order to carry out the 'clinical checking' that was emphasised by women. Women considered that midwives were there to adopt the medical role (the 'medical half'), and to make sure of progress in labour. They did not necessarily look upon midwifery as a unique source of support, rather, it was a model of care interchangeable with that offered by a GP or obstetrician.

A further exploration of women's views of antenatal care, conducted in Australia in 2005, looked into two aspects of continuity of caregiver: the frequency of contact with the same caregiver, and the extent to which the caregiver remembered them and their circumstances at each visit (Davey, Brown, and Bruisma, 2005). A range of care providers was represented: obstetricians, family doctors and midwives, in private and public settings in this survey of 1616 women. Analysis of the findings showed that women regarded seeing the same caregiver as less important than caregivers' efforts to recall significant issues from previous visits. These conclusions correspond to those uncovered by Freeman's (2006) literature review that sought to determine whether continuity of carer influenced women's satisfaction with midwifery care, and whether continuity of carer is a prerequisite for partnership relationships forming between midwives and women. Freeman examined 13 studies in total (including Fleming, 1998). For the 8 studies addressing satisfaction, Freeman concluded continuity of carer of itself was not a predictor of satisfaction.

The review did not find that women were preoccupied with the organisation of care system or model of midwifery practice. They were, however, invested in the nature and content of the care they received, specifically information sharing and shared decision making. The findings suggested that although working within this model increased midwives' job satisfaction and feelings of autonomy, it was not clearly demonstrated that women derived greater satisfaction from continuity.

Greater understanding of midwives' views came from a study examining their changing attitudes towards professional roles in response to the establishment of a midwifery group practice. (Collins et al., 2010). The practice consisted of a caseload model of midwifery continuity of care in Australia. A questionnaire survey was administered at five separate points over an 18-month period, and measured professional satisfaction, support and development, and client interaction. The survey showed a positive change in the midwives' attitudes to their professional roles in over time. This was particularly with respect to building relationships with women, continuity of carer, and developing professional autonomy. These qualitative studies were generally small in scale, however their findings suggested that further research was necessary to establish women's views of the service midwives in continuity practices seek to offer. Given the centrality of continuity models and relationships in maternity care, the revelation that women consumers of maternity services may not regard these features of care as essential, is problematic, but not new. Green et al. (2000) reviewed evidence available at the time to investigate what mattered to women about continuity of carer. They concluded that women may prioritise other aspects of maternity care than an established relationship with a midwife, and that an absence of relational continuity did not preclude good quality maternity services.

It is within the context of the redesigning a national maternity service around the concept of continuity of care, however, that understanding the theoretical extent to which the model is meaningful to women, and midwives, is important. Current UK policy has been used to explain the background of this thesis (Chapter 1). 'Better

Births' (NHS England, 2016), the report of the national maternity review conducted throughout 2015, is the mainstay of the policy. A significant part of the process used in the maternity review consisted of listening to women's views on how they wanted services to be shaped. The review proposed that that women wanted to develop relationships with maternity care professionals, and preferred receiving care either from a single midwife, or a small team of midwives throughout the childbirth experience. The report's descriptions and expectations of continuity and resultant relationship building relied on Sandall et al.'s (2016) systematic review, considered earlier in this chapter. Thus, continuity of care is one of the tenets of UK maternity services policy, which includes women knowing beforehand the midwife providing care for them in labour.

3.4.3 Quality of relationships

For this literature review, most studies considered that the success of continuity of care was dependent on relationships existing between women and midwives. There has also been interest, over a number of years, in exploring the importance of the quality of those relationships (McCourt, 2006; Hunter et al., 2008; Pembroke and Pembroke, 2008; Huber, 2009; Hunter, 2009; Dahlberg and Aune, 2013). McCourt's study (2006) was carried out in the UK from 1998 – 1999 and consisted of observations of interactions between women and midwives during the antenatal booking[6] interview. Forty individual interviews with both women and midwives took place, and different organisations of care provision (caseload or traditional)

[6] The 'booking' appointment is the woman's first contact with the maternity service, usually taking place early in pregnancy. It is an opportunity for exchanging information, history taking, and beginning a relationship between woman and midwife.

were compared. In this context, the traditional model comprised care shared between midwives, GPs, and obstetricians. The influence of settings in which the booking visits took place (hospital or community) was also factored into the study. The study revealed differences in the quality and nature of interactions and discussed the different approaches adopted by midwives. Encounters associated with the caseload model were characterised by a more collaborative partnership, with greater flexibility (e.g., style of questioning and length of consultation) and attending to women's individuality, when compared with the traditional care model. The traditional model was thought to result in formalised and ritualistic interactions i.e., adhering to a pattern of communication. Pembroke and Pembroke (2008) associated quality with spirituality or 'the quest for meaning, purpose and edifying values... (and the) ...transcendence of the ego' (p 322). In their view midwives were obligated to facilitate relationships with women that involved trust, honesty, respect, and sensitivity. In order to foster a relationship with a caring presence, midwives needed to be available, or engaged with women, and receptive to their needs.

The notion of the midwife-woman relationship parallels work by Hunter (2009), who studied women's perceptions of what 'being with women' signified, in San Diego, US. Hunter developed a conceptual framework of midwifery practice and found that 'being with woman' was an essential component and one that led to women being satisfied with their care. Among the elements of this component were sensitivity, personal attention, reciprocity, and nurturance. Using a qualitative research approach, Huber and Sandall (2009) observed and interviewed women who had experienced a relational continuity model of care during their pregnancy and labour provided by members of a self-employed midwifery practice in London. Midwives also participated in the study and the requisites for quality relationships were sought. The authors contended that relational models of care provided the context for the creation of calm. 'Calm' was found to be a key theme, and associated with freedom from agitation and maternal stress, better childbirth outcomes and greater satisfaction with care. Relational continuity was thought to

be the mechanism by which calm was engendered as it provided the opportunity for midwifery competence to be witnessed over time, and trust to develop between parties. Dahlberg and Aune (2013) used Q-methodology to assess how relational continuity influenced women's birth experience; the research was carried out in Norway with participating post-natal women. The women in this study regarded the quality of their relationships with midwives as being important for their birth experience. This was facilitated because trust was able to develop throughout pregnancy and prior to birth.

3.4.4 Partnership relationships

The principle of midwives supporting partnership relationships with women is well documented, and embedded in standards of proficiency for midwifery practice (NMC, 2019), NHS strategic planning i.e. The NHS Long Term Plan (2019) and the National Maternity Review: 'Better Births' (2016). Partnership relationships featured in other literature used for this review (Freeman, 2006; Boyle et al., 2016). The NMC (2019) has been emphatic with respect to partnership working. In its view, partnership extended to relationships with women, their partners, and families. Partnership led to women's preferences and decisions being endorsed, and strengthened their ability to care for themselves. The formation of working partnerships was argued as crucial for the core characteristics identified throughout the document. 'Better Births' (NHS, 2016) promoted women being in control of their maternity care, working in partnership with health professionals. The NHS Long Term Plan (2019) gave precedence to partnership approaches to care delivery throughout its recommendations, and in all sectors of health service provision. It seems, therefore, that the rhetoric of midwife-woman partnership is well developed in policy and education. Studies in the broader literature pay more critical attention to partnership relationships. Freeman's analysis of whether partnerships between women and midwives could be achieved outside of

continuity models was informed by 5 studies (2006). In contrast with policy and education standards discussed above (NMC, 2019; NHS England, 2016; NHS, 2019) through the review of qualitative research, Freeman critically examined the nature of partnership relationships and what their characteristics were. Partnership combined with continuity models, was associated with friendship, collaboration, and intimacy, for some women, as well as equality and trust. Ten years after Freeman's review (2006), Boyle et al. (2016) addressed the question of partnership relationships. In their critical exploration, they set out to determine the extent to which the UK Government's drive for partnership working had been implemented in the maternity services, and whether this approach was desired by women. They carried out a small-scale qualitative study of 16 women's experiences, at approximately 10 weeks gestation. Data was generated by the women through self-completion diaries, and by interviews between the women and researchers. At the outset, Boyle et al. presented a description of the characteristics of a partnership relationship used in the study. They identified dynamic relationships where both parties could exercise autonomy. They emphasised mutual co-operation, shared responsibility, and decision-making. They pointed to respectful and trustworthy negotiating. Boyle et al.(2016) did not provide a clear explanation of the models of care through which the participants' midwives operated. However, there is some indication that women were either booked under traditional community midwifery or received care from midwives at a midwifery led birth centre. The study suggested that partnership relationships were a function of the time available to develop them. They highlighted that more time allowed for individual consultations between woman and midwife meant a greater likelihood of mutually felt emotional bonds, and for more than just the physiological checks being completed.

3.5 Fourth defining attribute

Midwifery led care is woman centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers

Keywords searched: midwifery, midwifery led care, woman centred, choice behaviour, decision making, patient care, individualised, and combinations of these keywords.in titles and abstracts, and MeSH headings associated with these terms were used. Databases searched: Medline, Embase, Cinahl, PsycInfo.

The 2013 searches yielded 291 results. After removal of duplicates, irrelevant and inaccessible articles, full texts of 13 papers were retrieved and examined for relevance. This filtering process reduced the number of papers included to 7. spanning the years 1999 to 2012, with studies reporting on midwifery experiences in Sweden and Iceland, Finland, Australia, Canada, Japan, and the UK. The revised search in 2020 resulted in 4 documents of interest being included. The search strategy is illustrated in **Error! Reference source not found.** below.

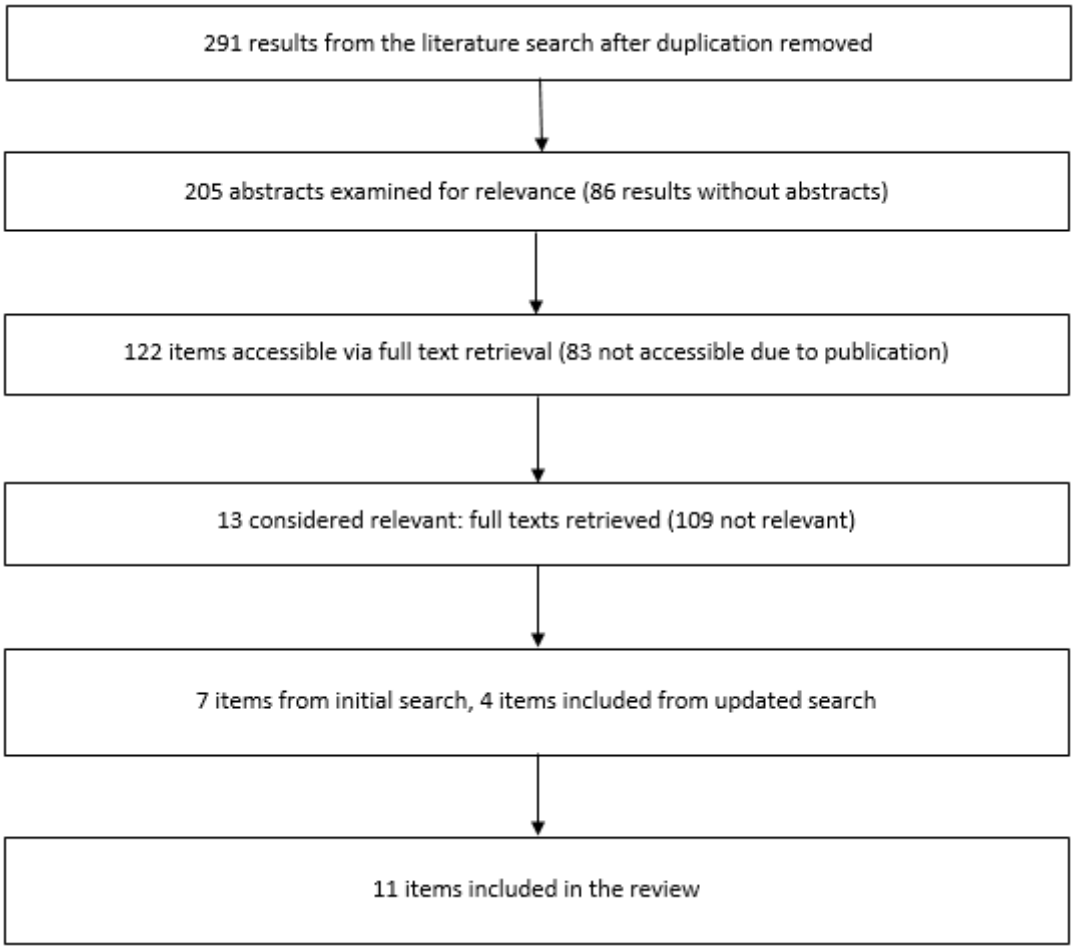

Figure 3-4 Search stratergy and results fourth defining attribute

The literature review found that components of this defining attribute were interrelated in the following ways. The ability to make decisions about care presupposes that there are choices available and that these choices are understood and accepted by midwives and presented to women. By advocating for women's choices, midwives provide care which takes the views and concerns of women into account, treating them as individuals. In addition, the backdrop of this attribute is UK maternity policy which advocates for choice for women with respect to

maternity care, and the need for services to be tailored to women's individual needs (DH, 2004; DH, 2006).

The interrelationship is illustrated in work by Homer et al. (2009), who developed a framework of the scope of midwifery practice in Australia by sampling the views of midwives and women. Interpretation of the literature identified 2 discrete themes of woman centred care: that it was central to midwifery and that choice and decision making were embedded concepts.

3.5.1 Women centred care: central to midwifery

Several studies concluded that women centred care (WCC) was a valuable quality of midwifery practice. The Australian Nursing and midwifery Council's investigation into the nature of midwifery practice (2004), reported in Homer et al.'s paper (2009) incorporated views of both women and midwives. Women participated by completing individual surveys whilst midwives were interviewed. The review found similarities between the two groups' responses. Value was placed on midwives being knowledgeable, respectful in supporting individuality and in communicating, and making women their priority. These qualities were thought to be best expressed within a continuity of care model. Midwives of this study described these supporting and communicating qualities as indicating WCC. Women expressed similar views about the qualities of WCC in a Japanese study comparing their experiences in different birth settings (hospitals, clinics, and midwifery led birth centres) (Lida et al., 2012). The study concentrated on women's satisfaction with their care, their perceptions of control in labour, and how connected they felt to their babies. Although the orientation of this study was to discover how perceptions of care and experiences varied with place of birth, it also revealed that WCC had a high correlation with care satisfaction, feeling empowered and therefore in control of labour. The RCM's position statement published midway between these two studies (Homer et al., 2004, and Lido et al., 2012) recognised similar principles of WCC (2008).

Other studies have attempted to theorise WCC through the means of concept analysis and model development. Berg et al. (2012) devised a model of WCC drawing upon 12 previously published qualitative investigations of women's and midwives' experiences of childbirth, and based on data from Sweden and Iceland. They identified 5 components. Three were considered fundamental to the model. Firstly, WCC required midwives to have reciprocal relationships with women, secondly, the birthing environment was appropriate for individual women, and finally, it signified midwives having grounded knowledge, i.e., accumulated from different sources such as embodied or theoretical. Maputle and Hiss's (2015) concept analysis showed that the defining attributes of WCC meant 'mutual participation and responsibility sharing', empowering women and enhancing their decision-making, respectful communication, cultural sensitivity and accommodating women's choices. Morgan's conceptualisation of WCC (2015) critically assessed assumptions made about empowerment. In her view, midwives were not responsible for empowering women, rather, their purpose was to facilitate conditions for women to empower themselves, thus positively affecting families and communities.

3.5.2 Decision making

Decision-making literature for midwifery care has explored both women's and midwives' perceptions. Levy (1999) conducted a grounded theory study of midwives' practice when facilitating women to make informed choices about their care. She identified the core category as being 'protective steering'. This happened when midwives tried to navigate the difficult task of not influencing women with personal opinions, or generating fear about potentially difficult choices, such as tests for abnormalities, and not encouraging unrealistic expectations or decisions that might be unpopular with colleagues. This sometimes led to women being steered to make decisions that the midwives considered to be safe or less

controversial. The exploration of individual choice was widened by Mander (2009) in her phenomenological study of maternity decision making at clinical, organisational, and policy level within the Finnish healthcare system. She argued that women believed their decisions and choices would be acted upon when trusting relationships between themselves and midwives existed. In turn, what helped midwives to facilitate women's choices was being able to work autonomously. The freedom for midwives to work autonomously relied on supportive organisational factors, such as management and policy approaches. Mander's (2009) argument, therefore, linked decisions made about individual care with factors outside of the relationship.

Correspondingly, the decision-making process was discussed as being multifactorial and dependent on a range of factors in a Dutch study of midwifery decision making with respect to referrals to obstetricians in labour (Weltens, 2019). The study identified midwifery knowledge (rational and intuitive) and the physical and social context of care as influencing decisions made about care. For example, midwives reported being more likely to refer to another professional sooner in a home-birth setting than at hospital. Midwifery autonomy and independence, which correlated with being free to make clinical decisions, was negatively affected by obstetric led environments. Though described as a relatively recent feature of practice, midwives did express their commitment to honouring women's choices. However, this commitment was felt to be unsustainable in acute situations, in which case midwives felt justified in overriding women's decisions.

The choices women make about childbirth options are influenced by information they receive about these options. Contemporary maternity care and policy acknowledges the importance of evidence-based practice. In Miller and Skinner's (2012) comparison of midwifery practice in different settings in New Zealand, findings suggested that midwives caring for women in labour in home settings were more likely to practise evidence-based care than when working in a hospital setting. This is likely to have impacted on the decisions women make about their care.

Smith (2016) conceptualised midwifery decision making as arising from a mixture of intuition (using pattern recognition and hypothesis generating), analytical, rational thought (interpreting cues gained from clinical investigations), and considering women's choices for care. Megregian and Nieuwenhuijze's (2017) case presentation singled out the importance of 'shared decision making' as a process by which decisions were respectfully made between care giver and patient, and where individual patient choices and best evidence were taken account of. In addition, shared decision making was a dynamic concept which increasingly incorporated relationship and quality factors. Thus, the relationship between the different parties and the way information was shared were significant. Megregian and Nieuwenhuijze (2017) discussed the challenges to the midwife-woman relationship when women declined recommended care, and cited instances in the US where forced compliance and coercion resulted from women's 'informed refusal' of care.

Noseworthy et al. (2013), in their New Zealand based study, discussed the evolution of decision making in healthcare from expertise focussed paternalism, where professionals made decisions for patients, to market driven informed choice adopted from free market economics where all parties had access to objective information, to the more recent shared decision making. Shared decision-making entailed information gathering and discussion between the parties followed by mutual choices about which decision should be taken forward. Clinicians brought their knowledge and skills whilst patients contributed personal preferences, experiences, and self-knowledge. Noseworthy et al.'s (2013) contended that neither of these systems took adequate account of the complexity of influences on decision making. Instead, a relational model of decision-making was needed, which recognised that women co-existed within families and were shaped by their socio-economic and cultural conditions. Women's actions and decisions were influenced significantly by these conditions; they did not make decisions solely to optimise individual self-interest.

3.6 Conclusions

This review has examined literature looking at evidence relating to the defining attributes of midwifery led care, and how they are enacted in clinical practice. There is sufficient evidence from the literature that each of the attributes is an integral part of midwifery led care, and that there is significant interrelatedness amongst the concepts.

With each attribute it is possible to discern theoretical exemplars of concepts. For example, exemplars of autonomy have been described as decision making capacity, power and authority, empowerment, and recognition of professional worth (Cotton, 2008; Hermansson, 2011; Matthews et al., 2006). For some attributes, the discussion has also focussed on disconfirming data, i.e., findings from studies that demonstrate that actual midwifery views or practice may not match the theoretical exemplars.

This issue was found for 'autonomy', where medical dominance was considered to influence midwives' autonomous practice negatively (Fleming, 1998), or relations with senior midwives curtailed midwives' agency (Hunter, 2005). It was also a feature of 'continuity of carer' where Freeman (2006) found that women did not feel continuity or carer models were required for good relationships with their midwives. Small scale qualitative studies formed the majority of literature retrieved and though findings are not considered to be generalisable to other populations or other settings, they do raise pertinent questions about how the attributes may be enacted elsewhere.

In general, the timeframe spanned over ten years and studies were drawn from countries with different principles of organisation of maternity care i.e., private/public models, and different models of midwifery care (continuity of care or carer, team midwifery or caseload midwifery). Therefore, for separate reviews of attributes, this degree of heterogeneity would have impacted on conclusions that can be made about how they are operationalised in practice. Though these are

limitations of the review, this situation can also be considered as justification to explore the defining attributes in their entirety.

Chapter 4 Methodology of The Study

4.1 Introduction

The purpose of this chapter is to outline and evaluate the chosen methodology for the research study: the overall framework which determined how the study was conducted and how the research question was answered. The outline and evaluation will also discuss the philosophical stance which influenced the methodological approach for the research. The principle methodological approach used was case study; the chapter will discuss different propositions of case study and which of these was selected as best fit for the research.

4.2 The research approach

The aims of the study were to discover how midwives working in midwifery led intrapartum care settings enacted the defining attributes of midwifery led care, and to develop a suitable conceptual model of the enactment of the defining attributes of midwifery led care, from the perspectives of study participants. The research question asked how the defining attributes of midwifery led care were enacted in midwifery led intrapartum care settings. The concept analysis, and the defining attributes of midwifery led care which were arose from it, was responsible for framing the research question (Chapter 2), and represented the starting point for looking at midwifery led care practices in different ways from those examined in existing literature. Existing literature had looked at a variety of aspects of midwifery led care. This was illustrated through work done in the following areas: comparisons of midwifery led care with other models, by systematic review and other methods (Sandall et al., 2016; Begley et al, 2012; Sutcliffe et al.; 2012), explorations of theories of knowledge related to midwifery led care (Anderson, 2002; Guiver, 2004; Maclellan, 2011), examinations of women's satisfaction with midwifery led care (Cheung et al., 2011; Williams et al., 2010) and metasynthesis of qualitative

research relating to midwifery led care (Walsh and Devane, 2012). These studies have added to the understanding of midwifery led care, and evidence from systematic review demonstrated positive clinical outcomes. However, there has been no comprehensive consideration of the mechanisms and strategies used by midwives in delivering midwifery led care. Walsh (2006) alluded to this shortfall in his assertion that only tentative explanations were available of the complexity of midwifery led care which lead to these positive outcomes for low risk women. Healey et al. (2020) later confirmed, through systematic review, that this detail had still not been investigated in wider literature, particularly relating to the second stage of labour. What is missing, therefore, is a thorough and inclusive conceptual framework that can provide insight and understanding into and critical analysis of the enactment of midwifery led care.

The choice of methodology was reached by weighing up relative merits of different options, in keeping with Crotty's (1998) declaration that the methodology and methods of a research study and reasons for choosing them, should be considered at the outset, and be directed by the research question. The nature of the research question for this study made it important for the data to be collected in the natural or real life setting of midwifery led care units where the phenomena of interest took place. The researcher's professional/insider knowledge of midwifery meant that decisions made about the methodology and research design had to include ways of capturing data about the context of the environment (philosophical and organisational). There was extensive interaction with research participants, resulting in deep understanding of midwifery practices and perspectives. The interaction was also complex and led to alterations to the initial proposal. The nature of the complexity and alterations will be revealed as part of the discussion of study design and methods (Chapter 5). The preferences for researching in natural settings and heeding the philosophical/organisational context, are based on assumptions about the relative merits of different methodologies and research methods, referred to by Bryman (2004) as issues of 'technical viability'. However, they also connected to what Janesick (2003) and Avis (2005) consider to be

methodological commitments that are appropriate for qualitative research. Avis's (2005) summary of commitments consists of several components. The most relevant for the current research were emphasising the importance of naturalism, favouring textual over numerical data, extensive interaction with research participants during direct fieldwork, flexibility in research plan to accommodate unanticipated events, and being mindful of the effect of the research decisions and perspectives in the process of gathering and analysing data. A qualitative approach, therefore, was the most appropriate for tackling these elements of the research which were crucial for answering the research question. It allowed for the complexity of midwifery led care to be considered including the underlying multifaceted influences on midwifery practice, and perspectives of both midwife participants and researcher. There was recognition from the researcher, however, of the wider debate about true delineation of qualitative and quantitative methodology. The research decisions were less about allegiance to one overall methodological position over the another, and more about heeding Avis's (2005) advice to focus attention on generating credible analyses of data using the most relevant research approaches and methods.

4.3 Qualitative research

Qualitative research is associated with exploring and understanding the social world and the interpretations held about it by participants and researchers (Bryman, 2004). It obtains in-depth data from relatively small sample sizes of participants (Ritchie et al., 2014). It observes phenomena first, then uses the evidence gained to build theory and knowledge (Bryman, 2004). Bryman (2016) uses the word 'naturalism' to refer to styles of research that seek to minimise the effects of artificially constructed data collection methods on the social phenomena being studied. This characteristic of qualitative research is aligned with social phenomena, including human behaviour, being explored in their natural environments rather than in artificially created ones, in other words, 'watching people in their own territory' (Pope and Mays, 2006, p4). Thus, in keeping with this

approach, the researcher observed, analysed, and interpreted exchanges between midwives and women in naturally occurring, pre-existing midwifery led intrapartum environments. The research sought to explore how a set of a priori defining attributes was enacted or operationalised in midwifery led care, through exploring the exchanges and interactions that took place.

The qualitative approach has traditionally been contrasted with quantitative research, where phenomena of interest, which appear in an objective or 'real' sense, unaffected by ideas of researchers, are examined and measured in terms of quantity, amount, intensity, or frequency (Denzin and Lincoln, 2005, p10). The quantitative approach is commonly associated with controlling variables that may affect the research environment, testing theories and hypotheses, establishing causation, and arriving at results that are generalisable to similar situations (Bryman, 2012). Differences between these approaches are conventionally attributed to their contrasting theoretical underpinnings, i.e., what is thought about the nature of reality (ontology), and how knowledge is constructed from it (epistemology) (Walsh, 2014).

In the current study, it was important to acknowledge the effect of the researcher's perspectives and values on what were constructed as the meanings of enactments of midwifery led intrapartum care, and that the account given would rely on interpretations of researcher's and participants' subjective impressions of the social world. Denzin and Lincoln (2018) address this issue by noting that the gaze of the researcher on the research subject is adapted by their own personal biography, thereby influenced by social class, race and gender perspectives. Qualitative research is often, but not exclusively, identified with 'constructionism'. Crotty describes constructionism as existing where meanings of the social world are constructed by human beings as they interact with the world (Crotty, 1998).

The idea of a strict dichotomy between quantitative and qualitative approaches, however, has been questioned. Bryman (2004) contests the idea of rigid delineation

between the two approaches, particularly as some research methods are used interchangeably; case studies have been used in both qualitative and quantitative studies. In addition, later editions of Denzin and Lincoln's major text on qualitative research, point out a 'blurring of divides' between the two discourses of qualitative and quantitative (2018, p3), and include numerous examples of qualitative research which has harnessed evidence from Big Data or software analytics, for example.

4.4 Comparisons of approaches

There are several different research approaches and methods that can be used to guide qualitative research, including ethnography and case study. Ethnographic studies require researchers to have an ongoing involvement in the research setting. They do this in order to determine how culture works as an entity, and how groups who share cultural norms, behaviours and beliefs in naturalistic settings operate (Cresswell, 201; Ritchie and Lewis et al, 2014). Active participation is a common feature, where researchers both participate in and make observations of the daily lives of the research subjects as a means of collecting data about social structures and other cultural artefacts (Prentice, 2013). Researchers build relationships with study subjects and in this way immerse themselves in the study setting. The shared patterns and values observed are described, analysed, and interpreted over the extended period of the research study. The current study was also concerned with context and influences on midwifery led intrapartum care; culture, both organisational and informal, were significant contextual features (Chapter 7). However, the focus on the study was the phenomenon of the enactment of midwifery led care in midwifery led intrapartum settings and an ethnographic approach would have addressed the research question tangentially and not specifically. The research question required in depth analysis of the phenomenon in question, and exploration from a number of different angles. Though cultural influences were of concern, they were not sufficient to properly address the

research question. The following sections of this chapter will introduce the case study approach and justify why it was expected to give rise to the credible evidence for the research.

4.5 Case study

Simons (2014) described case study as becoming popular in the 1960s and 1970s in the United States and the UK in educational research partially because of perceived inability of approaches used at the time (e.g., systems analysis) to include perspectives of participants or the socio-political context of curriculum innovation. Case study subsequently became associated with the 'quiet methodological revolution' of increasing use of qualitative enquiry in social sciences, extending to other disciplines such as healthcare, medicine, and social work. Simons (2014) also pointed out that case study was more of a principle of research than a research method. It provided a plan of action to guide decisions about the conduct of research. It was essential that in attempting case study, the particular phenomenon, or case, remained the focus, and that it was examined from a variety of different angles to achieve deep understanding of its particularity (Thomas, 2015). Yin (2014) contended that case studies led to in depth investigations in real world contexts, where the phenomenon was closely linked with its context.

Hyett et al. (2014) asserted that the advantage of case study was its flexibility in accommodating different study designs and methods and its association with different theoretical positions. They examined 34 published studies carried out by prominent case study commentators to assess the range of descriptions of methodology used. By measuring the descriptions against a suitable framework, they drew conclusions about the rigour of case study research. They derived a series of features that were considered to enhance the quality of case study. The features were as follows: whether studies adequately apply the methodological principles of case study or merely described case reports; whether conditions of

case selection were adhered to e.g., whether cases were justified as being exemplars or outliers of the phenomenon of interest; whether the boundaries of cases were outlined clearly; whether the interaction between researcher and case was outlined and issues such as reflexivity were apparent, and whether there was triangulation of data collection methods. Hyett, Kenny et al. (2014) concluded that although there were differences in the theoretical definitions of case study it was possible to arrive at essential characteristics to verify that case study had been appropriately used as an overall strategy in a research study.

There are several differences in approaches and conventions forwarded by key theorists of case study such as Stake (1995), Yin (2009), Merriam (1988) and Thomas (2011: 2016). Thomas (2011, p 93) produced a simplified amalgamation of different types of case study, based on propositions of these and other key theorists. He isolated the subject or focus of the study as the starting point from which other research decisions were derived. He proposed three categories of subject. These were key cases, which represented good examples of the case or phenomenon, outlier cases, which were different from the norm, or local knowledge cases, singled out because they were personally known to the researcher. Thomas (2011) identified three further interrelated categories in his summary: 'purpose', 'approach', and 'process'. Within each category there was a range of possible decisions to be made about the conduct of the study. These possibilities were based on the various approaches espoused by Stake (1995), Yin (2009), Merriam (1988) and others. The compilation of this summary reinforced the views about case study's flexibility and independence from prescriptive research methods (Simons, 2014) and wide diversity in study design (Hyett and Dickson-Swift, 2014). It also drew attention to differences in the key theorists' views about the nature and construction of knowledge, or epistemology. A critical analysis of these difference, and the link with epistemological positions, has been forwarded by Yazan (2015).

In Thomas' typology, 'Purpose' (2011) meant the reasons for carrying out research and could be labelled either intrinsic (interesting in themselves), instrumental

(helpful for examining another problem) (following Stake, 1995), evaluative (following Merriam, 1988) or exploratory (following Thomas, 2016). 'Approach' referred to how the case study was carried out. Thomas included theory building, theory testing, experimental and interpretive techniques in this category. Finally, 'process' dealt with the structure of the study, whether there were single or multiple cases, the relationship single studies had with time, or multiple studies had with each other. Applying Thomas's typology to this research was useful for giving structure to the research and delineating where the current research stood in relation to these questions. It also legitimised the current research by positioning its decisions amongst those of the key theorists. The decisions made in applying Thomas' typography will be discussed below, it is useful here, however, to further explore other principles of the case study approach that have influenced this research. They are 'boundedness' and 'context'.

The key theorists advanced other definitional principles of case study. Merriam's description was of an '...intensive, holistic description and analysis of a single instance, phenomenon, or social unit.' (1988, p21). Because of the focus on specific situations or entities they were 'particularistic', descriptive and heuristic. She considered the theoretical underpinnings of in qualitative enquiry, where it was necessary to uncover meanings of phenomenon by engaging in fieldwork in natural, bounded settings, where the researcher was an instrument of data collection, and where theory was built from inductive methods (Merriam, 1988). Contemplating the aspects that delimited the case was most important in that it determined what would and would not be included in the study. She emphasised that unless it was possible to recognise a boundary, or finiteness, to data collection, the object of research was more of a generality than a specific entity that a case exemplified. It is of interest that Merriam has extracted this quality of 'boundedness' as being the most essential for defining a case. As Yazan (2015) suggests, Merriam's emphasis on boundedness as being the main criterion for a case study to exist allows broader scope than Yin or Stake proposed of what can be considered case. Thus, the case

could be ‘a person …; a programme; a group such as a class; a school; a specific policy; and so on’ (Merriam, 1998, p27).

Stake (2005) also emphasised particularity and boundedness as features of case study, and in doing so was preoccupied with the importance of identifying the case itself, what lay within the boundaries and what lay outside of them. In addition to its boundedness, he recognised the importance of the contexts that might affect a case, the historical background, and the informants through which the case was revealed. By comparison, Yin (2009) offered a more methodical, technical definition whereby case study was an empirical enquiry that examined ‘contemporary phenomena within its real-life context especially when the boundaries between phenomena and context are not clearly evident’ (2009, p 18). Yin considered context to be highly relevant to case study because of its influence on the phenomena of interest. He contrasted this aspect with other research methods such as experiments or surveys where the ability and availability to look at the milieu and environment was either undesirable or not easily achieved. Yin (2014) was adamant that the case study approach was not particular to qualitative research, an indication of its fluidity. Case study could involve collecting quantitative, as well as qualitative evidence. It has been used to explain causal links in interventions where experimental methods could not adequately capture the complexity of real-life contexts.

4.6 Case study decisions for this study

Midwifery led care, and the enactment of its practices and attributes, exist within specific contexts and settings. Environmental, philosophical, and organisational factors are important influences and hence research into the complexities of how midwives give care to women should progress holistically, taking multiple perspectives into account (Walsh and Evans, 2014). Environmental, philosophical, and organisational qualities of midwifery led care are considered distinctive when

compared to other models of maternity care (Devane and Walsh, 2012; Sandall et al., 2013). In this research, the case study consisted of an exploration of the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings, which led to the construction of a conceptual model of the enactment of that care. From this position, qualitative case study was the methodological overview that influenced the design and methods of the study. Two cases of midwifery led intrapartum birthing units were selected, an AMU and an FMU, both were known to the researcher, and independently considered exemplars of midwifery led units[7]; they were both key and local knowledge cases. Emphasis has been placed in the relevant case study literature about defining the status of a case study involving more than one case. Thomas (2016) summarises this as an issue of the 'process' of case study design (outlined above), by which he meant its structure and style. He presented a critical discussion of studies containing multiple cases, stressing that multiple studies functioned to illuminate comparisons of interest between cases. The stance taken by the current research was of synthesising data from the cases, in order to magnify common aspects of the cases. This has been discussed as the 'case- oriented' method by Khan and VanWynsberhe (2008).

In line with Yin (2009), it was important for the researcher not to be blinded to other possibilities taking place in the interactions between midwives and women i.e., the researcher had in mind what defining attributes were, but was open to discovering other phenomena being present. The boundaries of this study were both geographical and conceptual. It was possible to 'fence in' the subject of study, and identify what would not be studied (Merriam, 1988). The separate physical entities of the midwifery led units represented geographical separateness from other parts of the wider maternity service provision of the NHS Trust that the cases related to.

[7] The selection of the midwifery led units is discussed in Chapter 5.

They were also conceptually separated from the same Trust in the content and model of care on offer.

Thomas (2016) proposed that the focus of case studies, the case, was made up of two components: the subject (e.g., person or place), and the analytical frame, or object. For this research the midwifery led intrapartum care unit was identified as the subject, while the object was the 'enactment' of the defining attributes of midwifery led care. The subject threw light on quintessential and problematic issues in enacting care. This was in line with Thomas' (2011) description of the subject of case study as the lens through which research questions could be viewed (2011).

From this position, qualitative case study was the methodological overview, or approach, that influenced the design and methods of the study. The approach was exploratory, in the sense of exploring behavioural, emotional, philosophical manifestations of the defining attributes of midwifery led care. Following Bryman (2012), the ontological and epistemological positions were constructionism and interpretivism, which are generally linked with qualitative methodology. These concepts have been discussed by Crotty (1998). He described constructionism, an ontological position, as existing where meanings of the social world were constructed by human beings as they interact with the world. The world view of constructionism contrasted with objectivism, which posited that the social world, like the natural word, presented itself as an objective reality, which could be discovered by using appropriate methods of enquiry. Interpretivism, an epistemological position, referred to the meanings that were attached to human behaviour (Bryman, 2012). It operated on the basis that for social action, the product of human behaviour, to be understood, it had to be seen from the point of view of the person carrying out the action. This understanding of the way knowledge was constructed has underpinned the research. As such, the meanings of the enactment of midwifery led care have been explored from the points of view of both midwife participants and researcher, the final written product of the

research has been constructed through the researcher being immersed in the complexity of the phenomenon in question.

4.7 Conclusions

This chapter has discussed the methodology used for the study, and the justification for the decisions made. The research question demanded a methodological approach that would make visible midwives' practices in enacting midwifery led intrapartum care. A qualitative case study approach made it possible to explore the cases in depth, from different angles, and to acknowledge influences and context of the cases. There are several key proponents of case study, whose positions influenced the methodological and procedural decisions of this thesis. The decisions have relied on these key proponents and existing literature, with respect to case study discussed in this chapter. Thus, the case study was underpinned by constructionism and interpretivism positions, reflective of a qualitative approach. The case study consisted of in-depth exploration of the appropriately selected cases, which were explored from several angles, using a multitude of research methods, in an 'intensive and holistic' endeavour (Merriam, 1998, p 21). Close contact and interaction with midwife participants enabled the researcher to understand the case from their perspectives. There were other implications of close contact, however, which are discussed in chapter 5, with respect to reflexivity. This chapter has outlined the methodological choices, the next chapter presents details of the methods used and design of the case study.

Chapter 5 Study design, methods, and analysis

5.1 Introduction

The purpose of this chapter is to introduce the research design and methods for the multiple qualitative case study. The aims of the research were to explore the enactment of defining attributes of midwifery led care in midwifery led intrapartum settings, and to develop a conceptual model of the enactment of the defining attributes. The case study approach meant that each of the two cases was studied in depth and in its entirety, the researcher and research methods were sensitive to the context of each case, and that the boundaries of each case were clearly established at the outset. These endeavours were directed at presenting the best opportunities for data to be collected that would answer the research question meaningfully. This chapter will consider reflexivity, sampling and recruiting participants, inclusion and exclusion criteria, and ethical considerations, as well as other features of the study design. It will then look at data collection methods and quality of research. The experiences and challenges of research will be discussed throughout.

5.2 Identification and sampling of cases and participants

Bryman (2012) recognised two levels of sampling in case study research, sampling of the case (or context) and sampling of participants. These levels, of both sampling and recruitment, are associated with different principles. The principle of choosing suitable cases was exclusivity in that a small amount of exemplar cases was desired. In order to achieve a manageable number of observations of midwifery led labour care, and ensure data adequacy, a larger number of both midwife and women recruits were needed. The case identified for this study has been discussed in Chapter 4, namely, midwifery led intrapartum care units which exemplified

enactment of its defining attributes. Therefore, the study required samples of cases, midwife participants, and women participants.

5.3 Identification and sampling of cases

Purposive non-probability sampling was used to select suitable study sites, or cases, for the research. This method was well suited as it allowed the researcher to have the research question at the centre of the decision, and strategically select cases which were ideal for answering the research question (Bryman, 2012). The cases were chosen because of the researcher's view that MLUs which were examples of positive outcomes associated with midwifery led care was likely to be staffed by midwives whose practices embodied the essential attributes of this model of care. The researcher's choice of study cases was pragmatic, including their geographical location, and based on areas that were accessible and about which the researcher had local knowledge. This has been referred to as 'judgemental sampling' by Harding (2013), which entailed being deliberately subjective in the choice, but focussed on the research question. At the time of selection there were several academic and consumer sources of information in the literature and online which could be used to select the exemplar cases. The Birthplace in England Study (Hollowell, 2011) was influential in highlighting midwifery led care and its benefits, or lack of adverse outcomes, in facilities that were geographically separate from the obstetric led intrapartum care units that the MLUs were associated with. Which? Birth Choices (2015) and Dr Foster (no date) were the websites accessed for information. These websites presented an algorithm for women to follow. They were able to choose their desired place of birth by comparing different facilities. Dr Foster (no date) provided a list of maternity services in the city chosen for this research. Searching Which? Birth Choices database produced results from 16 maternity services, each providing midwifery led intrapartum care. The website gave information about a large range of different aspects of the MLUs:

- Whether they were AMUs or an FMUs
- Their respective birth rates
- The arrangements of care and models of care
- Their inclusion criteria
- Facilities on offer such, as number of rooms
- Number of birthing partners accommodated
- Transfer time to the OU, if needed
- Equipment available including aromatherapy
- Strategies for coping with labour pain
- Women's opinions

Looked at in totality, these aspects gave an idea of the quality and priorities of the individual maternity services. They were indicators of levels of activity (and the likelihood of opportunities for the researcher to observe birth), inclusiveness (with respect to birthing partners), philosophies of care (in what was prioritised for pain relief) and environment. One question posed in the researcher's journal was 'should the case study be based around a model that includes a consultant midwife?' Consultant midwives promised clinical leadership in primary areas of normality and public health, including intrapartum care. In 2017[8], 46 of the 136 NHS Trusts in the UK, Channel Islands and Isle of Man employed consultant midwives. Some of these occupied positions of leadership with respect to the Trusts' Birth Centres (MLUs) (Wilson et al., 2018). Both study's sites received clinical leadership from a consultant midwife. This was verified during the selection process by questioning the respective Trusts switchboard operators. The consultant midwives became significant gatekeepers for the study, both were given the responsibility of

[8] This was during the period of data collection at the FMU

providing research governance by being the study's local (Trust-based) collaborators.

Case study designs can consist of either single or multiple cases; two cases were recruited for the study from the sample of possibilities. The recruitment methods are discussed below. Yin (2009) argued that a potential shortcoming of the single case study was that at the end of the data collection process, the quality and depth of collected data may fall short of what was expected initially. Recruiting two cases overcame the potential problem of lack of sufficient data and meant that a multiplicity of perspectives could be included. Proposing more than two units of study may have resulted in unmanageable amounts of data without contributing any more depth to the findings, particularly important given the timeframe of the research study and the researcher's part-time status.

Both cases were situated in densely populated urban areas. One was a freestanding midwifery led birthing unit (FMU) and the other an alongside midwifery led birthing unit (AMU). Case profiles included in Chapter 6 provide details of their make-up, environment, and organisation. Including both examples of MLU was more likely to reveal a wider spectrum of midwifery led care practices because of differences between the two types of MLUs. The research design dictated that the two different cases were to be studied consecutively. The importance of selecting a bounded case has been discussed in Chapter 4. The bounded case is one where the subject of study lies within a particular boundary, or is 'fenced in', thereby delimiting what is relevant to the study from what is not. (Merriam, 1998, p27). For the study to be successful in addressing the research question it was important to establish what the boundaries of the cases were, and to take these boundaries into consideration so that the appropriate phenomena could be explored. Table 5 llustrates the inclusion and exclusion criteria used for selecting cases (MLUs), these criteria reflected what lay either side of the boundary. Cases that satisfied the criteria were then evaluated for suitability. The aspects of MLUs that indicated quality and

priorities of the service discussed above helped to distinguish relative merits of the possible cases.

The Inclusion Criteria for Cases	
1.	Midwifery led intrapartum care was a key function of the MLU
2.	Midwifery led intrapartum care was being provided for women who fitted the criteria
3.	Midwifery led intrapartum care took place in the MLUs, with midwives being the lead professionals for the period of intrapartum care
4.	MLUs were located separately from the OU

The Exclusion of Criteria for Cases	
1.	Non-intrapartum midwifery-led care taking place within the MLUs
2.	Intrapartum midwifery care given to women not meeting the standard criteria for using the MLUs
3.	Midwifery care that continued after transfer to an OU
4.	MLU 'rooms' existing on an OU.

Table 5-1 Inclusion and exclusion criteria for cases

For the purpose of this study, with reference to the final criterion for exclusion, the decision was taken not to include cases where the MLU consisted of a few rooms situated in the OU as such settings lay outside the geographical boundary of the case and would have led to exploring inappropriate phenomena. This was because the influence of more medicalised practises characteristic of an OU, even for straightforward healthy women, would confound the study findings. The Birthplace in England (2010) found that 'low risk' women were more likely to have obstetric interventions in labour when cared for in an OU, compared to an MLU. Walton's

(2005) report of an action research project in an NHS OU, the aims of which included developing a strategy to increase normal birth, found that dominance of the medical model, risk aversion, and resource constraints negatively affected the success of embedded midwifery led rooms.

5.4 Identification and sampling of midwives

Midwives working at the study cases during the period of data collection were available and accessible by chance, and as a convenience sample to the researcher (Bryman, 2012) Table 5.2 summarise the inclusion and exclusion criteria, giving explanation and rationale where elaboration is needed. As the researcher became familiar with the study case, it became clear that seeking out the perspectives of key informants would add context and insight to the study. For this study the key informants were clinical leaders who were influential in the running of the MLUs[9]. The inclusion criteria were altered to accommodate this change in June 2016, three months after data collection had begun in the first study case. Other changes were made to the protocol, to be discussed in turn. The changes were approved through the Queen Square Ethics Committee's substantive review process (Appendix 2).

The Inclusion Criteria for Midwives	Rationale
1. Midwives have given voluntary informed consent to participate	
2. Midwives were NHS Band 6 midwives or above.	Denoting experience
3. Midwives had at least 6 months recent experience working in an MLU	This improved the likelihood that they were familiar and confident with the model of care and that important features of midwifery-led care were embedded in their practice. It also ensured that significant numbers of midwives were not excluded if frequent rotation is a feature of staff organisation in particular units.
4. Midwives planned to be present on the MLU for the duration of the data collection period as far as they could predict	This improved the likelihood of being able to interview midwives after having observed their practice.
5. Midwives were employed on a locum 'bank' contract, but fulfilled the criteria above	This allowed inclusion of midwives who are familiar and confident with the area who happen to work in this particular way.
6. Midwives were providing the majority of care, if working with students	Students participants must have agreed to the observation and there was sufficient space in the room for the researcher to remain unobtrusive.
7. Midwives conducted care in English	So that the researcher could be aware of verbal communication between midwife and woman.
8. Midwives were 'key informants'	Key informants in a research setting were material to the study because of specialist knowledge the research settings

Table 5.2 Inclusion criteria for midwives

	The Exclusion Criteria for Midwives	Rationale
1	Being a preceptorship midwife i.e. newly qualified/ band 5	Denoting less experience
2	Working under a Local Supervisory Authority Supervised Practice programme	Possible constraints might be placed on autonomous practice for such midwives.
3	Being employed by an agency do ad hoc shifts in different areas	Less likelihood of midwifery-led unit practices being embedded in their own practice, or be familiar and confident with the model of care. May have been more difficult to follow up.
4	Working with a senior student midwife who is providing a significant amount of care as a supervised practitioner	This situation would have reduced the amount of direct midwifery care that could have been observed.

Table 5-3 Exclusion criteria for midwives

The intention for the research was to observe midwifery care in 8-10 labours for each of the cases selected for the study, and subsequently interview the midwives who had provided the labour care. Having some flexibility about the numbers of midwives recruited was in keeping with one of the aims of qualitative research to continue data collection until saturation of emergent themes and explanations had been reached (Kelly, 2010). The research cycle for each study case had been set at 18-weeks. Allowing for a period of familiarisation and information sharing about the project, the research design envisaged that observations and follow-up interviews would take place between weeks 5 and 16 of the cycle. Kelly(2010) suggested that researchers should justify they had selected enough participants to provide a full exploration of the topic. However, she counselled that although reaching theoretical saturation was desirable, it had to be balanced against the analytical task that generating significant amounts of data would create. The rationale for selecting 2 cases has been laid out above. Similarly, the rationale for aiming for 8-10 observations and interviews per research site was based on judgements that Kelly (2010) outlined. 8-10 observations and interviews per research site represented an optimal number of encounters that would produce

rich and varied data, also considering the logistics of travelling to the different sites and part-time status of the researcher.

As many midwives as possible were recruited to the study during the research cycles in both study cases. Having a significant number of consented midwives meant when the researcher was present at each site there would be midwives who had already consented to having their labour care observed. The unpredictability of spontaneous labour onset made forward planning problematic. Thus, when most of the midwifery teams had given consent to participate, the researcher was able to organise her presence at the study cases according to the participant midwives' work rotas, which she was given access to. Most midwives worked 12-hour intrapartum shifts.

The midwife participants of the study had varying years of experience as registered midwives and working in midwifery led services and/or environments. Years or experience proved to be a significant and positive factor for the midwives and is discussed in Chapters 6 and 8. Table 5.4 summarises theses details for both study cases.

Case Study Site	Range of years as registered midwives, in whole years (median number of years)	Range of years of experience in midwifery led care, in whole years (median number of years)
AMU	3 -20 (9)	1 to 9 (5)
FMU	3 - 20 (15)	1 to 20 (6)

Table 5-4 Range in experience of midwife participants for both study cases

5.5 Identification and sampling of women

The appropriate sample included any woman who intended using the MLUs for labour and fitted the usual criteria set by the MLUs. For both MLUs, however, online information from Which? Birth Choice (2015) specified that women could discuss using the units if even if they did not fit the criteria included on the webpages. Time spent in data collection fieldwork revealed the fluid nature of the MLUs' inclusion criteria (e.g., expansion of the criteria to accommodate women with diet-controlled diabetes or colonised by Group B Streptococcus). The overriding requirement, therefore, became that women were eligible if midwives were the lead professionals. For the initial design of the study, women were identified through convenience because they intended to use the selected midwifery led units during the period of data collection. Changes in the recruitment of women became necessary during field work at the first study case, the AMU. Recruitment was widened to include those attending antenatal appointments in community settings such as GP surgeries. The inclusion criteria were also expanded to include young women (16 -18 years). These changes were agreed with the Research Ethics Committee (Queen's Square) via the Substantive Review process (Appendix 2).

Inclusion and exclusion criteria for women are presented in Tables 5.5 and 5.6. It was important not to exclude women who did not communicate in English. The researcher believed that given the ethnically and racially diverse populations of women using the maternity services of the MLUs it would have been unethical to use non-English language speaking as an exclusion. At the time of data collection for the AMU, 20% of households included residents for whom English was not the first language, in 10% of these households there were no fluent English speakers

[Anonymous, 2015][10]. For the FMU, 35% of adults used a main language other than English, with a quarter of this group not speaking it well or at all [Anonymous, 2015][11]. There is little guidance about measures to include non-English speakers in research in childbirth, and limited reference to whether non-English speaking was widely used as a criterion for exclusion. In Rocca-Ihenacho's (2016) doctoral thesis, an ethnographic study of an urban freestanding midwifery unit, a bilingual research interpreter attended interviews with the Bengali women participants who were not confident in English speaking. For many studies accessed during the current study the intentions were not clear with respect to exclusions of non-English speakers. This situation, as highlighted by Homer (2000) and Murray and Buller (2007) may still be the case.

For this study, steps were taken to ensure that relevant information, such as the Participant Information Sheet (PIS), and consent form could be made available to non-English speaking women. For each study case, the NHS Trust and Local Council were contacted for a list of common non-English languages in the areas. The intention was to translate the research information when required. The information packs for women included brief information about the research in each of the common languages, and details of how to receive translations. One set of translated information was requested during recruitment at the AMU. The inclusion and exclusion criteria are presented in Tables 5.5 and 5.6.

[10] The source is a multilingual advice service, anonymised to maintain anonymity of research case.

[11] The source is a report of census statistics (2011) of English proficiency in the area of the FMU

The Inclusion Criteria for Women	
1.	The midwife assigned to them had consented to participating
2.	They consented to taking part in the research
3.	They had mental capacity
4.	They met the usual inclusion criteria of the MLUs
5.	They were at least 16 years old at the time of the proposed observation
6.	They understood the written information provided, translated if needed
7.	They received intrapartum care on the midwifery led unit for the period of the observation

Table 5-5 Inclusion criteria for women

The Exclusion of Criteria for Women	
1.	The midwife assigned to them did not consent to participating
2.	They did not meet the usual inclusion criteria of the MLUs
3.	They could not understand the written information or translations

Table 5-6 Exclusion criteria for women

5.6 Ethical considerations

The study was approved by the Research Ethics Committee on the 12th of November 2015 (Appendix 3). There had been minor amendments made to the original protocol at the request of the Research Ethics Committee. One of these was the addition of contact details on the PIS. The other required confirmation from the researcher's professional body (The RCM) of what actions should be taken in an emergency (Appendix 4). A more significant change was for women to be consented by the researcher and not by the midwives as originally planned. In addition, the Research Ethics Committee opined that woman should be consented days in advance of labour, with their consent being confirmed when attending in labour. The original plan, of midwives consenting women when they attended the MLUs in 'early' labour, had been rejected. The committee acknowledged that consenting women days before labour raised the possibility of consenting women who may not eventually end up being part of the study. The required amendments were made and subsequently the Trust Research and Development departments for both study case granted permission for the study to take place.

Substantive amendments to the research protocol were granted in June 2016, during data collection for the first study case[12]. The changes were designed to optimise recruitment of women to the study. By contrast, most of the AMU's core midwives had been recruited, and it was in the context of discussions with then, and an AMU manager, that the ideas came about. The AMU manager expressing concern that the research should progress and make visible what happened at the 'birth centre', was an indication of the rapport between researcher and participants. The participants were rooting for the study to be 'successful'. In the same way, at the beginning of data collection at the FMU, the researcher was

[12] Fieldwork began for the first study case on the 10th March 2016

questioned about how the research findings could help the unit in in its challenges with the link obstetric unit. Bell (2011) discussed what motivated people to consent to research studies and identified 'participation as quid pro quo' as a possible explanation. In the current study, the midwife participants may also have been seeking fair exchange for their contributions. The substantial amendments also indicated the practical need to adapt methods and activities according to what was encountered in the research process. They are presented in Table 5.7 and discussed in later sections of this chapter.

Substantive Amendments to Research Protocol	
1.	Removal of time limit for data collection at each study case. The research would be concluded when the 8 - 10 observations had been carried out
2.	Key informants such as midwives influential to the cases to be interviewed
3.	Women could be approached about the study when attending the MLUs for reasons other than possible labour, e.g. changes to fetal movement or possible pre-labour spontaneous rupture of membranes
4.	The age limit for women to be lowered to 16
5.	Recruitment of women to take place at community antenatal clinics, as well as at the MLUs
6.	Community midwives were permitted discuss the research with eligible women attending their clinics

Table 5-7 Substantive amendments to research protocol approved by research Ethics

5.7 Consent

The principles of Good Clinical Practice in Research (GCP)[13] guided the design of this study. This is particularly true with respect to consent. Consent was addressed through giving potential participants written information, available in several languages for women, and one to one verbal discussions about the study. The consent forms and PIS were based on NHS Health Research Authority (HRA) templates, thus ensuring an appropriate standard of information was included in these documents (Appendices 5 and 6). The researcher consented all participants individually. Iphofen's (2005) critical analysis of informed consent suggested that researchers faced challenges in the amount of information they give to participants. Enough information was needed to give participants full understanding of what was expected of them, but not so much that deterred participants from taking part if the commitment appeared onerous. One particular statement in the PIS for midwives was brought up in the information sharing sessions at both study cases: the obligation to escalate concerns of poor practice to the midwife shift co-ordinator[14]. Although this obligation is embedded in The Code (NMC, 2015, p 14-15), in the context of observers scrutinising individuals' practice, it was seen as intimidating to a small number of midwives and acted as a disincentive to participating. This was articulated in the researcher's fieldnotes:

" An underlying issue in recruiting midwives is their suspicion that in scrutinising practice I may end up being critical of their decisions, and take my concerns forward by discussing with managers." (Fieldnotes, 19th March 2016)

[13] GCP standards is an internationally recognised framework used for designing, conducting, recording and reporting trials which recruit human subjects as participants.

[14] The statement is contained in PIS for women, page 4.

Reluctance to participate in research due to concerns about repercussions was reported as a by Burns et al. (2012) as an ongoing problem.

'The EOI (expressions of interest) form hung on the staff room wall for two weeks without any names being listed. I sensed there was a certain level of suspicion amongst the staff as to what the study might involve and who the findings might be reported to.' (Burns et al., 2012, p 53)

The consent forms and PIS were developed using templates from NHS Health Research Authority (HRA) webpages. Guidance from the HRA also highlighted problematic issues with the procedures for gaining consent, for example, applying requirements and procedures too rigidly for the type of research being undertaken. It suggested that a proportional approach was needed, which weighed up the levels of risks and benefit of the research and tailored the amount of information given to reflect these levels. Midwives and women were provided with the following information:

- The name of the researcher and contact details for enquiries
- The broad aims of the study
- An assurance of confidentiality and anonymity in reports of the study
- Arrangements if unsafe/poor practice was observed (in midwives' PIS)
- Response of the researcher in an obstetric emergency (in midwives PIS)
- Information about data storage (adherence to University of East Anglia Policy on Research Data Management)

Although midwives were able to distribute the PIS to women, both in the community (for the FMU) and in the MLU, Research Ethics Committee approval was contingent on the researcher gaining their consent to participate, this was thought to reduce the possibility of midwives coercing women to participate. In the researcher's absence, midwives gave eligible women information packs and if interest was shown, advised the women to make contact, and recorded women's details for the researcher. In fact, midwives contacted the researcher to inform her of the interest being shown. The process for consenting women is illustrated in Figure 5-1 below.

Observation of midwifery practice was restricted to no more than 6 hours with either party retaining the right to stop the observation at any time. The follow-up interviews with midwife participants were planned to take place in private, and in a venue to suit the midwife. Of the three observations of practice involving 4 midwives, one midwife was interviewed after the observation at the AMU. For the FMU, one midwife had already been interviewed, and was unavailable after the observation. Two other midwives (caring for one labouring woman at the FMU), were also unavailable.

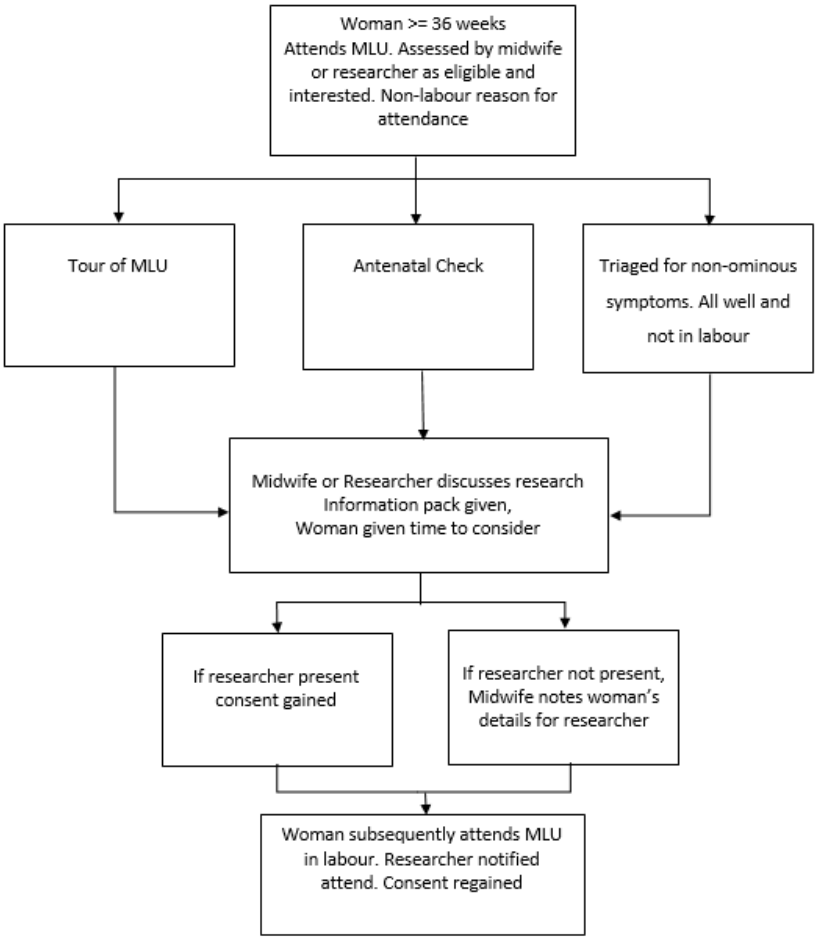

Figure 5-1 Process for consenting women

The researcher 'followed' the shifts of the midwives who had already consented to participate. Most midwives from both study cases had consented such that on each shift that the researcher was present there were opportunities to observe labour care. As the research proceeded, discussions between the researcher and her University PhD supervisors resulted in the decision to interview all the midwife participants, to solicit their views and opinions of midwifery led care, and how they enacted its defining attributes. This led to the collection of data from 15 interviews, providing rich and varied insights for the research question. Thus, the research design developed as the study progressed, demonstrating flexibility in the methods, and creativity in the face of unanticipated circumstances. Avis (2005) refers to this favourably as a 'flexible plan of inquiry' which forces researchers to constantly reflect and evaluate the direction of the research and incorporate other means of addressing the research question where needed.

5.8 Confidentiality

Confidentiality was ensured for the three participant groups: the study cases, the midwives, and women. The features of confidentiality were described in the PIS for each group. The identity of the cases was kept confidential and made anonymous in the data. Participants were assigned a numerical code, and not referred to by name in any of the research outputs. The document linking participant with numerical code was securely stored on a password controlled electronic device, accessible only to the researcher. It was necessary to retain the identifying data as it allowed for the planning of follow-up interviews with midwives whose labour care had been observed, and for theses interviews to be cross referenced for member checking. Participants were assured through the PIS that any direct quotes attributable to them as individuals used in the report of the study and any other publication would be anonymised. Confidentiality and anonymity were particularly important as protectors of the FMU data. Maintaining confidentiality of study cases

was more problematic than for individual participants. Kamanzi and Romania (2019) critically analysed the principles of confidentiality and anonymity in an era of Big Data[15]. They suggested during the data collection process, the volume of participants and others, related and unrelated to the research, are involved in the research, making it possible to reidentify the research setting. Furthermore, there was little indication that midwife participants were concerned about their MLUs being named, and some indication that they welcomed their midwifery craft to be showcased.

Written data generated in the course of the study was kept locked and secure in a cabinet within the University. During periods of data collection (whilst the researcher was away from the university) the data collected was kept securely by the researcher. Identifiable information, such as the correspondence from the Research Ethics Committee, was stored electronically and password protected, accessible only to the researcher. All data will be kept secure for 10 years in line with the Data Protection Policy of the University of East Anglia.

5.9 Service User Involvement

The NHS Patient Information guidance and Health Research Authority guidance were used to formulate PIS and consent forms, and inform the general design of the study. The guidance covered topics such as testing the PIS with potential participants. This guidance led the researcher to contact the local Maternity

[15] Big data comprises structured, semi-structured, and unstructured data which can be mined for information for a large amount of applications and institutions, and for a variety of functions, such as answering research questions. .

Services Liaison Committee (MSLC)[16], which represented the concerns of services users to the local NHS Trust. The MSLC was invited to provide critical commentary on the study, specifically the PIS and consent forms. The MSLC suggested the forms should use plainer language and recommended guidance from the Plain English Campaign[17]. This combination of advice was used to redraft the documents. Users of a local branch of a national internet-based consumer group, Mumsnet, were invited to suggest ways of minimising the impact of having a researcher in the birthing room. Most of the respondents (n=13) had given birth previously. Their concerns were about taking cues from the woman about how she wanted the researcher to be, where she should sit, and whether she should initiate conversation. They were also concerned with consent and being able to withdraw it at any time during the observation. Their comments were also used in redrafting the PIS and consent form and were influential in how the researcher carried out the physicality of the research.

5.10 Risks and benefits

The study did not involve clinical interventions or changes in treatment, however, the researcher acknowledged that the presence of an observer in the birthing room

[16]Local Maternity Voice Partnerships took over the work of the MSLCs in 2017, as a means ensuring effective co-production of key decisions in maternity services, involving service users, providers, and commissioners. Maternity Voices Partnerships arose from maternity services transformation plans, in line maternity policy shaped by the Better Births review (NHS England, 2016).

[17] The researcher used the Plain English Campaign's guide: 'How to write medical information in plain English' published in 2001.

could act as an intrusion into the birthing process. Observations of labour are not unusual occurrences. Midwifery students spend a proportion of the early part of their training observing care in labour, which is not considered to interfere unduly with the midwife-woman relationship. Observations of labour may be perceived as a different unknown quantity by midwives and women. The potential risk was addressed by the researcher, an experienced clinical midwife at the time, using knowledge and insight about the process of normal birth to minimise the effects of the intrusion. This entailed being quiet and mindful during observations, sensitive when interviewing midwives, arranging interviews at convenient times for midwives. Midwife participants did not directly benefit for their involvement in this research, however, there were indirect opportunities for benefitting from reflections on midwifery led care which the conduct of the research prompted. Midwife participants were also keen for the profile of midwifery led care and MLUs to be raised by the findings of the research, bringing with it self-examination of good practice. The research was considered low risk to the researcher, with no lone worker issues to consider.

5.11 Good practice

The researcher is a registered midwife and bound by the Nursing and Midwifery Council (NMC) The Code – Professional standards and behaviour for nurses, and midwives, and nursing associates (2015). The researcher had been trained in Good Clinical Practice in Research prior to the study commencing. The University of East Anglia sponsored the research and arrangements were made for insurance and/or indemnity to cover legal liability for any harm that came about as a result of the study.

5.12 Commencing fieldwork

The process of identifying suitable study cases has been outlined above. Heads and Deputy Heads of Midwifery, and consultant midwives of the potential cases were first approached in December 2014 (FMU) and March 2015 (AMU). The process of negotiating access took 6 months for the AMU and 2 months for the FMU. However, because final ethics approval was granted in November 2015, the first of the research cycles commenced in March 2016, and ended in August 2016. The researcher committed to two to three days per week for this period.

Initially an 18-week research cycle was planned for each MLU. It was envisaged that this length of time would enable the researcher to become immersed in the research setting, allow sufficient time to successfully recruit participants, and complete data collection. The research cycle took account of the need for the researcher to become familiar with the case in the early weeks of the fieldwork, and for the midwives to get used to her presence. This was the 'engagement phase' of the researcher-participant relationship discussed by Bell (2011), consisting of building rapport, risk assessment, and issues of consent. Ritchie et al. (2013) proposed a series of measures to engage with participants about research topics. One was the use of recruitment materials to generate awareness and interest in the study. Research posters and information sheets with contact details of the researcher were used as visual stimuli, and information sharing sessions were held whenever midwives and other team members had time to attend them. The researcher planned for these sessions, which took place in the MLUs' office spaces, to provide an opportunity to respond to questions about the research, and distribute PIS and consent forms. Midwives were originally asked to contact the researcher voluntarily if they were interested in taking part. This reflected the desire of the researcher not to coerce them to participate in the study inadvertently. As the research cycle progressed it became apparent that midwives should be approached individually about the research. The midwives, who appeared initially to be wary, responded more openly to this tactic, and it was

adapted for the subsequent research site. In this way most of the midwives consented immediately to participating and data collection was arranged to take place on the days that consented midwives were working.

Table 5.7 provides details of the substantive amendments made to the research protocol, some of these amendments have been discussed. During the course of the research, it became evident that the original time frame would limit the opportunity to recruit women participants successfully. This feature was also amended by the Research Ethics Committee and research site research governance committee.

The research had been designed originally so that women were given information about the study during the tours of the MLUs, which for both MLUs they attended around 34-36 weeks of pregnancy. This would have allowed sufficient time to digest the information and, when attending in labour, women would have had prior knowledge about the study, with the midwife participant going through the stages of gaining informed consent. When this scenario was no longer possible, due to the Research Ethics Committee decision, the tours of the MLUs became the opportunity to consent women. In the initial stages of the study, the researcher focussed being present at the weekly tours, distributing information and talking to groups and individuals.

Taking part in the tours at the first study case was advantageous as it gave the researcher a deeper understanding of the how the AMU midwives defined themselves to others. The mood of the tours was inclusive and welcoming. It emanated desire to accommodate the women, however, operationally the tours also gave midwives the chance to screen women for eligibility to use the AMU. Midwives were able to scour women's notes to check that their circumstances matched the inclusion criteria.

Following substantive review, the researcher gathered information about suitably busy community antenatal clinics connected to the AMU. Contact was made with

the new set of gatekeepers, the community midwives and team leaders, via email and face to face team meetings. The researcher contacted another set of gatekeepers: the community midwives and team leaders, GP, and Health Centre practice managers. The plan to recruit had evolved as follows:

- Continue with AMU tours
- Continue presence on AMU.
- Continue to recruit midwives
- Attend a small number of GP surgeries and Health Centres. Community midwives to discuss study with eligible women, researcher to approach women after antenatal appointment to attempt recruitment

Recruitment in GP surgeries and Health Centres began in July 2016 and continued until the beginning of September 2016.

The research cycle for the FMU lasted from March 2017 to October 2017. The researcher committed to two to three days per week of fieldwork for this period. Midwives were recruited following individual discussions about the study. Antenatal clinics were held at the FMU. Eligible women were identified by the ward clerk and after permission was giving by the midwife, women were approached women about the study. The ward clerks were significant allies in the process of recruitment. The researcher soon learnt that as team members, they had a wide brief with respect to the undertaking of FMU work. The following comment from field notes underlines their importance as conduits of the FMU philosophy of care:

'I noticed the same at the AMU, the ward clerk is the member of staff who has a wide brief with respect to the organisation of the work. She is literally the gate keeper, she lets women and families in, welcoming them in a way that is not characteristic of the equivalent in an obstetric unit. The obstetric labour ward has to limit access to women … So, my enquiries are often directed at ward clerks: 'is there an antenatal clinic today where I can recruit eligible women?', for example.' Field notes July 2017

The research cycle coincided with a significant drop in the FMU birth rate. This is discussed in Chapter 7 as a consequence of the opening of an alongside midwifery led unit by the same Trust as the FMU, and the perceived reluctance of community midwives external to the FMU to discuss it with women as a potential place of birth. Details of the results of recruitment are presented in **Error! Reference source not found.**

Case Study Site	AMU	FMU
Number of midwives recruited	10	15
Number of women recruited	14	13
Number of births observed	1	2
Number of midwife interviews	9	7

Table 5-8 Recruitment and research activity

5.13 Data collection

Data was collected in keeping with methods commonly used in qualitative research in general, and case study designs in particular (Yin, 2009; Thomas, 2011; Stake, 1995; Creswell, 2012; Denzin and Lincoln, 2018).The methods were direct non-participant observation, semi structured interviews, field notes, and document analysis.

5.13.1 Direct non participant observation

Direct non participant observations were made of midwives giving care to labouring women in each of the MLUs. 'Care' included, for example, communicating with the woman, establishing her clinical/social history in order to assess risk, carrying out clinical observations, confirming that woman and fetus are well, offering support, encouragement, and advice, facilitating birth, and providing immediate postnatal and neonatal care. Non-participant observation meant the researcher did not provide care to women participants, however, as discussed below (section 5.15.3), being a midwife gave rise to several instances inside and outside of the birthing rooms, where pressures to participate in care were significant.

The researcher was also present in staff meetings and other interactions between midwives in the context of their work, e.g., in staff rooms, where valuable insights into contextual features of the care were gained. These included discussions about midwifery led models of care, decision making processes and the values underpinning care. Field notes were made of these interactions. Hodnett et al. (2012), in reviewing institutional birth settings, point to the importance of design features, physical artefacts and organisations of birthing rooms, i.e., the birthing environment, in relation to midwifery led care. Therefore, observations were also made of these non-human aspects. Field notes of these interactions were anonymised and did not identify individual midwives.

The process of observing labour care began when midwives started to provide the types of care described above. Data collection began when midwives started to provide care in labour as described above. The researcher was present in the birthing room. Observations of care were recorded using pens/paper and an electronic tablet, depending upon the preference of the women participants. An indicative observation tool had been developed to guide collection of data. However, it was found to be somewhat artificial and a barrier to understanding the entirety of the case. The observation tool was used only as an aide memoire for the

defining attribute themes. Mulhall (2003) discussed differences between unstructured and structured observations as differences between paradigms of positivism and interpretivism / constructionism. Structured observations maintained objectivity and distance from the subject of research, unstructured observations acknowledged the effect of the researcher in interpreting research data. Unstructured observation, in taking account of context and the influence of physical environment, blended in with qualitative research.

In keeping with non-participant observation, the researcher intended to be as unobtrusive as possible; decisions about where to sit were arrived at through discussions with the midwife and woman. On the occasions when the midwife left the room or was relieved for a break by a colleague, the researcher left the room also. Data collection outside of the room continued only if the midwife continued to plan or discuss decisions about care with colleagues or other professionals, or other opportunities arose that were relevant to the research.

In general, the length of labour is unpredictable, and the intention was not to observe the entire labour and birth as this may have lasted many hours. The plan was to limit observations to 6 hours, but allowing flexibility to accommodate relevant events in labour. The three observations of the study lasted less than two hours. Longer spells of observation may have disadvantaged the study by leading to researcher fatigue, to the generation of unmanageable amounts of data. Individual midwives were asked to consent to being observed on more than one occasion. Ritchie et al. (2014) proposed that whilst the presence of researchers may influence the behaviour and interactions they are observing, the effect was limited.

Data from the observation guides was recorded using Microsoft Office software (Word and Excel) and qualitative data processing software (NVIVO). NVIVO® 12 (QSR International Pty Ltd, 2018)

5.13.2 Semi structured Interviews

Semi structured interviews were carried out with midwives from both study cases. This is a method widely used in qualitative research and case study (Garish and Chau et al., 2004; Lagendyk and Thurston, 2005; Walshe and Chew-Graham et al., 2008; Dow, 2008 and 2012; Powell, 2013). The purpose of the interviews was to allow for follow-up and clarification of issues arising when observation and field notes were obscure or unclear, and to contribute to assessing the validity of the observation and field note data i.e., triangulation. Interviewing midwives gave them the opportunity to contribute their insights and meanings of the phenomena being studied.

An indicative interview guide was developed to provide some direction for the interview. The interview guide prompted midwives to be questioned about their perceptions of midwifery led care. From this point midwives were able to define and clarify their stance on the midwifery practice.

The research design was altered to accommodate interviewing all MLU midwives who had consented to the original study. All such interviews took place in the MLUs. Interviews were audio taped to aid accuracy and to avoid distraction that might arise if the researcher was taking notes. However, for one midwife not wishing to be recorded, a detailed written record of the interviews was taken. Audiotapes of the interviews were transcribed verbatim by the researcher.

5.13.3 Field notes

Field notes were made at the beginning of the research cycle for each study case. Field notes enabled reflexivity to be considered i.e., acknowledging the perspective of the researcher and the effect of this on the research process, particularly as the researcher is a clinically practising midwife. Field notes allowed recordings of

reflections, conversations, actions, opinions, initial interpretations, and views to take place. The field notes also contained the observations of physical artefacts and the context of work spaces discussed above. They included drawings, diagrams, and photographs of each case to aid recall about design and organisational features of the physical environments. Research participants were not included in any photographs taken, in order to preserve their confidentiality and anonymity. Photographs were used to aid the researcher's memory of the study cases. They were not included in the written thesis and are not intended to be used in any other publication arising from the research, so that the anonymity of the study cases is preserved.

5.13.4 Document analysis

Data collection included accessing and analysing documents considered to be valuable at revealing the influences of midwifery led care in each case, and what the organisational factors were. These issues contributed to establishing the context, a necessary component of case study research. Documents included written philosophies of care, national and local guidelines and protocols, minutes from staff meetings and other reports of relevant events. The study did not access women's maternity records.

Bowen (2009) defined document analysis as a systematic process where documents of interest were retrieved, reviewed, and interpreted to elicit meaning, and enhance understanding. Documents are socially constructed facts, used in socially organised ways. They provide information on history, goals, and objectives relevant to the research programme. Bowen (2009) proposed that this method of data collection was particularly suitable for qualitative case studies because it contributed to understanding the phenomenon under scrutiny, and the context it operated in.

The presence of generic documents anchored the MLUs to the wider maternity service. Where documents were customised for the MLUs and not generic, there was an opportunity to emphasise the particular philosophy of care of the MLU. Equally, when documents were directed at women ('women facing') as in information leaflets about the MLUs, they were less directed at risk assessment and emergency measures and more designed to celebrate the women-centred environments. Thus, the documents and artefacts available in the midwifery led units (MLUs) were a mixture of utilitarian guidance and information, and publicity material. The guidance directed and instructed midwives in the administration of their midwifery service. The 'women facing' materials included positive written feedback from former service users and extensive photographic displays of babies born at the MLUs. The data resulting from document analysis, quotations, or other excerpts, for this study was organised around the priori themes of the original defining attributes. Due to the complexity and heterogeneity of the content, document analysis was completed by hand, separately from interview and observation data. Data from document analysis has been included in the findings chapters (Chapters 6 and 7).

This mixture of data collection methods was an effective means of triangulation, where information is gathered from different sources with the aim of contributing to the development of themes and knowledge about particular phenomenon. Grbich (2007) counselled that drawing from various sources and methods could simply increase the amount of data to be processed without consolidated findings from the research. However, drawing from a range of methods satisfied the requirement for case study to consider variety of different angles in order to achieve an in depth understanding of the research subject. Appendix 8 contains a summary of the documents accessed.

5.14 Data analysis

The Framework method was used to organise data generated from the study and facilitate data analysis. The method was outlined by Ritchie and Spencer (2014), and described as having originated in the 1980s at the National Centre for Social Research to be used for large scale policy research. The method is an example of thematic analysis or qualitative content analysis (Gale et al., 2013). One of its advantages is the highly structured output of the matrix-based format, which allows increasingly abstract levels of themes and sub themes to be matched directly with raw data, and vice versa. This is an important step as it makes it possible for themes to be easily traced back to the source of the data, including participant and study case. Because of the inherent transparency of the process, comparisons can be made within cases and across cases (Gale et al., 2013). Decisions about assigning data to themes are also visible. The framework method contributes to triangulation as all data from different methods is analysed in the same way but is identifiable separately. Through this process the initial analytical framework of codes and categories is applied to the subsequent data allowing categories to be merged or new ones derived.

Descriptions of framework analysis refer to the value of research teams sharing these tasks to improve consistency and rigour, for example, by debating contrasting interpretations of the data (Ward and Furber et al., 2013). In this educational project however, these analytical steps were carried out by the researcher, and all data from observations and interview transcripts was included. The researcher consulted research supervisors periodically about the findings to discuss the process and justify decisions made about developing themes. These opportunities for review added to the rigour of the data analysis.

Formal data analysis commenced when all the data from the two cases had been transcribed. Computer assisted qualitative data analysis software (NVIVO 11 & 12) was used as a data analysis tool. However, as Ward et al. (2013) pointed out in their

worked example of the framework method, although computer packages are useful for organising and sorting data, qualitative data analysis is a conceptual process requiring critical thought, and the responsibility for interpretation rests with research investigators. Nevertheless, using a computerised method improved the visual display of the thematically driven framework matrices.

The initial concept analysis for this study identified defining attributes of midwifery led care as the basis of the case study. These defining attributes became pre-existing a priori themes against which midwifery led intrapartum care was explored. For the data analysis, different approaches were possible (Gale et al., 2013). Taking the deductive approach would have entailed coding data against the a priori themes first, whilst allowing other unexpected codes to emerge from the data to provide context. However, the decision made for this study was to apply open coding techniques to all transcripts initially, rather than slotting them into the a priori themes, followed by applying the codes developed from the initial work to the a priori themes. The problem of analysis in studies where both deductive and inductively derived themes are to be included has been discussed by O'Keefe et al. (2015), who conclude that decisions should be driven by the aims of the study.

5.14.1 Analysis process

Data analysis proceeded using the five stages of the framework method outlined by Ritchie and Spencer (2002): familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation. Table 5.8 presents the recruitment and research activity for the study, which included details of the dataset, i.e., 16 interviews with midwives and three observations of midwifery practice. Data from document analysis was analysed separately. The interviews

were audio recorded[18] using a recording device and IPAD (the IPAD provided a back-up recording) and transcribed by the researcher using Microsoft Word. Hand written observation notes were also converted to Microsoft Word documents. The process of transcription was carried out throughout the activity of data collection. All interview and observation data were used in the analysis. Srivastava and Thomson (2009) have suggested that with large datasets, including all of the data in the analysis may not be practicable. For this study, however, as the dataset was manageable, no advantage was seen in excluding transcripts from analysis. Data from collected documents was analysed by hand, organised around the a priori themes of the defining attributes. The process of data analysis as it applied to the framework method is discussed below and was carried out using NVIVO 11 & 12.

5.14.2 The stages of Framework analysis

The familiarisation stage involved the researcher becoming immersed in the data by reading and rereading all transcripts, and during this activity, becoming aware of key patterns and ideas arising from the data. Field notes were read alongside the observation and interview transcripts as this gave insight to the context of the research setting and ensured that reflexivity was acknowledged. During the familiarisation stage the field-notes continued so that a record of the developing impressions of the data could be maintained.

The second stage of identifying a thematic framework was achieved through recognition of recurrent and important themes. Some commentators include an

[18] One FMU midwife preferred not to be recorded. Her interview was captured through hand written notes, converted to a word document.

additional stage of the framework approach here to further clarify the process. Hence, Gale et al. (2013)[19] included 'coding' as a separate stage, which is directly linked to the thematic framework. Coding entailed classifying the data by applying labels or codes line by line, indicating what the researcher had interpreted as being significant. Gale et al. (2013) referred to the 'open coding' where codes are derived from as many different aspects of the data as possible. Identifying the framework proceeded by recognising recurrent and important themes. The emerging themes derived from the familiarisation phase formed the backbone of the thematic framework because codes arrived at in that stage were grouped together to form categories. The categories, therefore, consisted of codes which represented similar ideas and concepts.

The developing analytical framework, step 3 of the process, was applied to subsequent transcripts. This process is also referred to as 'indexing' and it was during this stage that sub themes and themes were revised as a result of the comparisons taking place between the initial themes and those emerging from the ongoing data analysis (Ward et al., 2013). After this point, the inductively derived themes were coded against the a priori defining attribute themes (discussed in Chapter 6). Themes which were not associated with the a priori defining attributes became the 'open coded' material discussed in Chapter 7.

Charting, or summarising data into the analytical framework (using the matrix organisation), was carried out by 'lifting' original data from transcripts into charts. However, using NVIVO 11 & 12, the 'lifting' was achieved electronically. The charts were headed by the subthemes and themes derived either inductively or deductively. The charts or matrices enabled original data from transcripts to be

[19] Gale et al. (2013) identified 7 stages of the framework process.

cross referenced against themes so that a clear audit trail could be seen and justification for the interpretation made transparent.

The final stage of the process, synthesising the data by mapping and interpreting, required charts to be systematically examined so that further checking of summaries against the original data and possible refining and/or merging of sub themes and themes could take place. Appendix 7 is an example of framework matrices for several defining attribute sub themes derived from interview transcripts for both of the study's cases.

This method of data analysis took into consideration data that addressed a priori themes, derived from the study's dataset, an important step in exploring how midwives enacted the defining attributes of midwifery led intrapartum care in cases selected for the research. It was also important to understand the context of midwifery practice. Incorporating open coding themes in the analysis ensured that interesting and significant factors were not overlooked.

5.15 Quality issues

The researcher has sought to address quality issues in the design of this research, taking into account the ways that quality is envisioned for qualitative research Following Lincoln and Guba (2018) quality is represented in case study research by credibility, dependability and confirmability, and transferability.

5.15.1 Credibility

For research to be credible, the design has to demonstrate a series of components: prolonged engagement in the field and persistent observation, triangulation, peer

debriefing, and member checking. For the current study, the researcher was present in both study cases for five to seven months, being present at the study cases for two to three days per week. This period of immersion in field work allowed the researcher to understand the cases in depth, generating sufficient data to answer the research questions. The research design included several methods of data collection for exploring the phenomenon in question. Data was consistent across observations of midwifery practice, interviewing midwife participants. Data analysis contributed context, and indicated procedural tensions that informal and formal observation and interview drew attention to, which enhanced the picture of participants' perspectives. Peer debriefing was mediated through interactions between researcher and research supervisors. The aim was for the researcher to acknowledge the decisions taken about the research; this was particularly important in the data analysis phase. Member checking gave research participants the opportunity to engage, agree, or disagree with how the raw transcribed data was coded and interpreted thematically. Enabling participants to view analytical constructs of the verbatim data as well as the verbatim data was considered more rigorous. Participants were provided with a matrix construction of the themes identified for the research, and thus, shown how their verbatim data contributed to the themes. As a result of member checking, one of the participants considered that she had not adequately represented her practice with respect to clinical guidelines during her interview. The data was altered to reflect what she believed.

5.15.2 Dependability and Confirmability

These indications of research rigour oblige the researcher to outline their methodological and interpretive decisions such that the reader of the research report is able to discern how conclusions had been reached. For the current study, the use of NVIVO 11 and 12 qualitative data management software enabled auditing of the methodological decisions made during data analysis and

interpretation. A priori themes (the defining attribute themes) formed the basis of enquiry for the research. The process of coding data at themes, and deriving open codes was simplified by the use of software, however, all coding decisions were made by the researcher, and are retrievable from NVIVO

5.15.3 Reflexivity

Houghton et al. (2013) point to the importance of acknowledging the researcher's influence and personal contributions in the choices made and interpretations of research. If qualitative research is associated with exploring and understanding the social world from the perspectives of participants and researchers (Bryman, 2004), acknowledging reflexivity is part of the that process of exploration for the researcher. There are multiple accounts of reflexivity, and its significance for conducting research (Merriam, 1998; Finlay, 2002; Burns et al.,2010; Lumsden, 2013; Enosh and Ben-Ari, 2015; Hamilton, 2020). Merriam (1998) asserted that investigator characteristics were material to the research study, and consequently, the research had to be specific and transparent about what the investigator brought to the process. Acknowledging existing ideas and opinions about the subject of the research was incumbent on the researcher as they were the primary instrument for gathering and analysing data. Hamilton (2020) explored the process of her research project through a reflexive gaze, and in doing so offered several observations. She observed that a researcher's positionality informed every aspect of the decision-making and process of research, and that reflexivity required the researcher to recognise, explore and understood how their social background and assumptions were material to the process. There is less guidance in the literature, however, on how to incorporate a reflexive account into research. This lack of clarity is emphasised by Hamilton (2020) who argued that authentic reflexivity in practice demanded more than a theoretical and detached account of the researcher's social location for it to contribute to the criticality of the research project.

In the current research, exercising reflexivity was a continuous activity. The most significant factor was the researcher's status as a clinical midwife at the time of data collection, and specifically her orientation towards midwifery led care settings as satisfying occupational and social environments. The researcher considers that her views and opinions influenced the choice of topic, and design of the study. In turn, the views and opinions underpinned decisions made in data analysis and interpretation. The desire to understand what participants understood of the phenomena directed the research's methodological approach. Many of these understandings and impressions were documented in field notes and discussed, sometimes challenged, in meetings with research supervisors. The field notes incorporated a reflective account of the experience of conducting research.

Burns et al. (2010) examined the reflexivity where midwives as researchers explored phenomena in settings that were familiar to them, and drew attention to the dilemma of being both an insider and outsider. Being a registered midwife, the researcher encountered both familiarity and unfamiliarity in the research setting. However, the dominant position was one of being accepted into the fold as an insider by participants. This was an advantage in most ways; however, it was challenging to withhold help with clinical tasks that would have assisted midwives in busy times. The following come from AMU field notes:

'***I cannot help but feel comfortable, but want to maintain a bit of distance (frisson) so that no one forgets why I am here' AMU Field notes April 2016***

'I arrived here and (name of midwife) says "thank god you are here!" The birth centre was busy and there was a multip[20] fully dilated with thick meconium. (name of midwife) asked me to help the other midwife transfer her to the labour ward. Of course, I am willing to do anything to help in an emergency but when later asked to give oxygen to a women in the assessment room I think the point

[20] A multiparous woman: one who has already given birth.

along the participant/ non-participant continuum has shifted and I should think of an intention to practice[21]' AMU Field note, August 2016

At other times, acting as an 'insider' was less controversial. The researcher regularly helped with cleaning and tidying at the MLUs, accompanying midwives to local shops to buy lunch, and supporting students or midwives with educational assignments. These tasks were easier to carry out because they were uncontested in the eyes of the research ethics and governance frameworks which dictated the operational boundaries of the research. Notwithstanding the role of research ethics and governance in protecting participants (and researchers) and ensuring quality in research projects, the experiences of negotiating insider and outsider positions can be complex and stressful, but are not necessarily considered when formalising ethics approval. Hamilton (2020) refers to this as the gap between what happens in the field, and what is written on the ethics form, and suggests that the process of ethical approval should include enquiries about reflexivity.

5.15.4 Transferability

For transferability to feature in qualitative research Houghton et al.(2013) propose that detailed descriptions of the research process and findings, or thick descriptions, must be available for the reader to judge whether they are transferable to another context. The necessary detail includes raw data and descriptions of context. The contents of chapters 6 and 7 represent the thick descriptions of the study cases, and indicate how the defining attributes of

[21] Prior to statutory supervision being removed from statute in 2017, midwives were obliged to notify their 'intention to practice' to a Supervisor of Midwives in each health authority where they worked.

midwifery led care are enacted in the midwifery led intrapartum settings selected for the research. Transferability to other cases of midwifery led intrapartum care would require the same boundaries to be applied to those cases as in the current study. It would exclude, for example, midwifery led care settings which were conceptually and geographically different. Thomas (2016) argues against pursuing transferability (referred to by him as generalisability) in case study research in social sciences (where human behaviour is explored), preferring instead to regard any comparison as stemming from 'a fluid understanding explicitly or tacitly recognising the complexity and frailty of the generalisations we can make about human interrelationships' (2016, pp 69-70).

5.16 Conclusions

This chapter has explained the research design used for the case study, including ethical considerations. It has outlined decisions made about sampling and selection of the different levels of participants, the process of field work and data collection methods, and indications of quality specific for qualitative research. The chapter has also laid out the Framework Analysis approach used for the research. The next two chapters outline the findings from data collection and analysis. Chapter 6 details those which address the research question. Chapter 7 gives an overview of themes derived from open coding. These themes, though not material to the research aim and question, present interesting and relevant knowledge about factors influencing the enactment of midwifery led intrapartum care.

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Chapter 6 Presentation of findings – deductive themes

6.1 Introduction and organisation of findings chapters

The purpose of the findings chapters (Chapters 6 and 7) is to present detailed accounts of the results of data collection and analysis. The research question sought to explore how the defining attributes of midwifery led care were enacted in midwifery led intrapartum settings, using a multiple case study. Four defining attributes were identified by the concept analysis (Chapter 2), each expressed as an overall theme representing a set of interconnected principles (see Figure 6-1). These defining attributes became the a priori themes used to organise the data gathered from interviews and observations, and derived from document analysis, a deductive process described in Chapter 6. The list of included documents is included as Appendix 8. Through the method of Framework Analysis (Chapter 5) coded data that harmonised with a priori themes were organised further into a typology of sub-themes and descriptors. The sub-themes and descriptors showed to what extent the defining attribute themes were present in the case studies' midwifery led units, what, if any, variations existed, and how they were enacted in midwifery led practice. In this way, the findings chapter describes the relevant strategies, techniques and practices midwives use, and their perspectives about midwifery led care.

In addition, the expectation was that not all the data collected would match a priori themes. Different patterns of ideas and concepts would emerge inductively from the fieldwork. In this way there was a parallel process of newly derived data driven themes being generated. Thus, two new themes were identified. Each of them was examined and refined further to see the extent to which they were related to the four defining attributes themes, before determining that they were independent concepts. The newly derived themes are considered in the next chapter (Chapter 7).

The two chapters, therefore, will consider the themes and sub themes both deductively and inductively developed relating to both cases of the study using the 'case-oriented' approach to cross-case analysis. The advantaged of the 'case-oriented' method have been explored by Khan and VanWynsberhe (2008) as discussed in Chapter 5. It consists of amalgamating data from both research sites rather than carrying out separate interpretations for comparison. Other themes that emerged from the research, though interesting in themselves, have been excluded where they did not assist in addressing the research question. In keeping with case study, this chapter will first provide descriptions of the study's two cases through general case profiles and a summary of participants' characteristics and how they contributed to the study.

6.2 Case Profiles

6.2.1 Case 1: The Alongside Midwifery led unit (AMU)

Case 1 is an alongside midwifery led intrapartum care unit (AMU) which is part of the maternity service provision for a large National Health Service (NHS) hospital Trust in Southern England. The Trust serves a densely populated, ethnically and racially diverse inner-city area, one of the 20 most deprived local authority vicinities in the country.

Alongside midwifery units (AMUs) are situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on available, although women may need to be physically transferred to the obstetric unit if they need obstetric care.

The AMU is collocated with the obstetric led intrapartum unit. It occupies a discrete part of the ground floor of the wing of the hospital dedicated to women's and children's healthcare, whereas the obstetric led intrapartum service (OU) is housed on the 3rd floor. Proximity to the obstetric unit, and nearby neonatal intensive care

unit, means that women and/or babies can be transferred relatively easily in cases of urgent need for obstetric, anaesthetic, or neonatal care.

Having opened in 2010, the AMU is one of the larger of such units in England. In a city where there is a significant number of such units, Case 1, during and just after the time of data collection for the study, had one of the highest numbers of births i.e., there were 800 between April 2106 and April 2017. However, the AMU transferred the fewest number of women and babies to the linked obstetric unit with a transfer rate of approximately 19%.

The AMU's five birthing rooms, offices, kitchen, and staff toilet arise from either side of a central corridor, with a small open space separating 2 rooms available for women to keep active. The lighting in the corridor is subdued, there is no access to any other part of the hospital along its length; the layout, with its lack of thoroughfare, gives an impression of seclusion and privacy.

The reception area, separated from the corridor by a security door, is the large space by the external entrance to the AMU. It serves as a waiting area with chairs lining the 3 walls, and a permanently switched on mounted television. This is where women enter the AMU waiting for their labour to be confirmed by a midwife (a private assessment room adjoins the waiting area where women can be seen and examined), or where women and birthing partners assemble for the regular tours of the birth centre. The ward clerk occupies the desk space of the waiting room, dealing with the administration of the centre's activities.

The AMU also provides space for its midwives to manage the service from its main office. It is the space whose use is exclusive for midwives, students, and other maternity staff to congregate. It displays all the paraphernalia and associated items for the birth centre: clinical records, guidelines and policies, work rotas and the white board where written information about the labouring women is communicated.

The contents of the main office identify the centre as being part of the bigger operation of maternity care as much of the information attached to its notice boards or contained in its numerous files is generic and likely to be found in other areas such as the antenatal clinic or obstetric led labour ward.

An interesting exception is the student 'Welcome Pack' that describes learning opportunities student midwives can expect to be exposed to during their birth centre educational placement, including physiological third stage. It is unlikely that a physiologically managed third stage would be presented in such a positive light on the OU. The pack includes a suggested reading list of books belonging to a genre of childbirth related literature advocating physiological birth and minimal clinical interventions. The message of the welcome pack appears to be that AMU is an alternative to the medicalised environment of the obstetric led labour ward.

The décor of the AMU is striking in that it is clear that great effort has been made to create a look not immediately recognisable a clinical environment: the five birthing rooms are spacious with darkly coloured walls and darkly stained laminate flooring, the regular double beds are almost luxuriously adorned with velvet and satin spreads and pillows with matching covers, the wooden cot resembles a domestic one, and is not the plastic box of many maternity English maternity wards. There are two-seater sofas in each room, dressed in soft cushions. Wall hangings are textured, mood lighting allows darkness to be achieved at any time of day. An initial impression could well be 'Premier Inn'[22].

The equipment of active birth are the purpose built stools, inflatable rubber balls and the birthing pools. These feature in all the rooms and proclaim the commitment the centre has to physiological childbirth and encouraging women to use resources

[22]'Premier Inn' is the name of a chain of British hotels.

other than the traditionally used bed. The bed is a double one, cushioned by an undivided mattress. The bed, in contrast to a traditional labour room one, invites women to rest and sleep, rather than to be used to labour on. There are, however, some obvious signs of a clinical or hospital setting such as the emergency call bells and tubing for Entonox.

The AMU is staffed by a core team of approximately 16 midwives of varying degrees of experience and years of service, maternity support workers and ward clerks. Student midwives spend some of their practice placement on the unit and are supported by a clinical practice facilitator. Some of the midwives maintain a community post alongside the intrapartum care post, they are rostered to do clinics in community settings as well as shifts on AMU. However, the overall organisation of care is directed towards looking after women in labour. Although Case 1 is part of a wider maternity service it became clear through the interviews conducted with midwives for the study that there was an absolute focus on birth and a self-conscious distinction between them and the obstetric led intrapartum unit.

There is a 'senior' midwife (NHS Agenda for Change[23] Band 7) leading the team, and a consultant midwife overseeing the unit. During the interviews the midwives almost invariably referred to the presence of a supportive team leader as being a protective factor for successful midwifery led care.

The AMU operated an 'opt-in' referral system, where women had to specifically choose to use the unit for labour and birth. By contrast, an 'opt-out' system would have designated the AMU as the default option for women considered to be 'low-risk' with uncomplicated straightforward pregnancies and medical histories,

[23] Agenda for Change is the name given to the main pay system for midwives, nurses, and other staff in the NHS; doctors, dentists and senior managers are not included.

providing that they did not prefer to use the obstetric-led unit. McCourt, Rayment, et al. (2014) discussed the relative consequences of 'opt-in' and 'opt-out' systems for AMUs and conclude that the latter approach reflected the organisational aim of normalising the provision of midwifery led care for low-risk women which may not have been as easy to achieve in obstetric led settings.

One of the notable features of the AMU was the tour of the unit offered to women in the third trimester of their pregnancies who were considering giving birth in the unit. The tour allowed women to see the birthing rooms and imagine what a birth experience at the unit might be like. The women were introduced to the philosophy of the unit, to the principles of active non medicated birth and the idea of birth with minimal intervention. Midwives reviewed the maternity records of women who attended the tours and assessed whether they fitted the criteria to use the AMU for labour and birth. Where there are risk factors, women were able to discuss their particular circumstances with the Trust's consultant midwife, the lead matron for the AMU, or a consultant obstetrician. Thus, in some circumstances of intermediate or higher risk of complications, an individualised care plan was created to accommodate women. Following the period of data collection, the criteria for using the birth centre expanded to allow women with a confirmed Group B Streptococcus infection (where intrapartum intravenous antibiotics were recommended) to use the AMU.

6.2.2 Case 2: The Freestanding midwifery led unit

Case 2 is a free-standing birthing unit (FMU) located on the third floor of an NHS health centre in southern England. The FMU had been established in 2008, a year after the opening of the health centre, and shared the premises with a GP practice and 'walk-in' urgent care facility, a pharmacy and community health offices. The FMU was situated in an area of both historic economic deprivation and, more

recently, wealth generating multinational corporate financial activity, all concentrated in a relatively small geographic area.

The unassuming architecture of the health centre gave little clue about the activities of the birthing unit taking place a few floors above the surgery. The external façade gave no indication that one of the flagships of evidence based UK maternity care provision (Birthplace in England Collaborative Group, 2011; RCM, 2012; National Maternity Review, 2016; National Institute for Health and Clinical Excellence, 2014; Royal College of Midwives, 2012) was situated on the busy high street.

The ‘freestanding unit‘ label implied that the service was self-contained and self-sustaining, this was not the full picture, however, as organisationally, Case 2 was part of a large NHS Healthcare Trust. The Trust website (not cited to maintain anonymity) provides information about the care it gives to several million people, operating several major hospitals and community health centres. Case 2 is one of two FMUs the Trust offers to the local population. In addition, although the initial intention was that the FMU would be available to women from surrounding postcode area, this policy was subsequently altered, and at the time of data collection there are no restrictions against women from other areas having access to the FMU for intrapartum care.

The additional complexity of the FMU came from its being the base of one of the community midwifery teams provided by the maternity service. The 'linked' hospital is the place women or babies are transferred to if delays, problems, or emergencies arise in or around labour and birth, in order to receive obstetric, anaesthetic, or neonatal care. Midwives of the community team also staff the FMU. It was an example of a team with an unusual organisational feature whereby midwives from the team provided care for all stages of the childbirth continuum. From the initial 'booking', to the postnatal discharge from midwifery care, and including preparation for birth classes, post-natal and breastfeeding drop in

support clinics, and intrapartum care for those women who fitted the birth centre's criteria. The model of care reflected the original intention for unit's midwives to offer continuity of care to local women, including care in labour for those meeting the unit's criteria of uncomplicated pregnancy (Rocca-Ihenacho and Herron, 2011). The type of integrated care thus described was considered to be unique by the midwives at the FMU, however, information compiled by the Royal College of Midwives (RCM) published in 2012 (RCM, 2012) suggests that in general FMUs provide a similar range of antenatal and postnatal services, thereby redirecting the focus away from looking after labouring women towards the entirety of childbirth. There are examples of FMUs in Bath, Lancashire, Essex, Argyll, and Powys, which are organised in this way. Given the numbers of births accommodated on average at FMUs (the figure of 200-300 births per year was put forward by the RCM in 2012) it may make sense to diversify their services in order to remain economically viable.

The physical space offered by the FMU conveyed the fact that the unit satisfied a multitude of functions. The front door opened onto a large central communal area furnished with comfortable cushioned chairs, small tables and chairs, a mounted television screen, and a wall covered with colourful pictures of babies born in the unit. It served as a place for childbirth related activities such as meetings of the breast-feeding support group. Birthing unit staff (midwives and maternity care assistants, ward clerks and students) would congregate there for lunch; families of women occupying birthing rooms would lounge on the sofas and use the adjacent kitchen to prepare food and drink. Unlike the AMU, the FMU kitchen facility included the option for women or birthing partners to prepare food and drinks without needing to seek permission. Thus, unhurried social interaction was possible between all inhabitants; there was a sense of what Fahy (1998) referred to as 'being' a midwife rather than 'doing' midwifery in the apparent 'idleness' of the exchanges

There were five birthing rooms arranged along corridors leading off from the communal area. Each room was large, accommodating birth pool, double bed, birth

ball and floor mattress. There were soft furnishings and wall hangings. Dimmer switches allowed for mood lighting. There were ensuite shower rooms, and access to the balcony that surrounded the third floor, equipped with tables and benches, and divided by wooden partitions to ensure privacy. The emphasis, therefore, was on welcoming women into a 'home from home' environment that encouraged mobility in labour. There were no formal restrictions on how many birth supporters could accompany the women, or how long women could stay in the unit after giving birth. Walsh (2012), in a metasynthesis of midwifery led care, refers to these features, where women participants used metaphors which evoked homeliness and comfort in their descriptions of birthing units.

Tucked between two of the rooms was a private assessment or consulting room where women were seen for follow up antenatal or post-natal checks. There were storage spaces for drugs and equipment, and separate toilets. The 2 office areas reflected the distinct activities of the FMU. One was dedicated to the functions of team as community midwives. For example, it was the site for the first pregnancy appointment women had with a midwife, where they were 'booked' for maternity care (social, medical, obstetric histories were shared, and appropriate care planned). The other was used to support intrapartum care, characterised by the white board were details of labouring women were recorded.

In both spaces written information saturated the walls. There were displays of signs of the administration of healthcare: the midwives' on-call rota, whom the unit's birthing pools had been leant to, and notices of study days. There were also indications of the birthing unit's connection to the host Trust and link obstetric unit evident in the array of policies and guidelines, contact telephone numbers and criteria for reporting adverse clinical events. These artefacts demonstrated the relative dependence or interdependence of the birthing unit. The fact that midwives from the FMU will were occasionally obliged to travel the 3 miles to the obstetric unit to assist with the workload at times of high activity or staff shortage clarified further the nature of the power balance in the relationship.

Though care focused on all phases of childbirth (antenatal, intrapartum, and post-natal periods), the subject of the case study was the FMU's as provider of an intrapartum midwifery led service, which was delineated from its other functions by an identifiable boundary, a prerequisite for case study enquiry (Merriam, 1998; Thomas, 2016). In a recent systematic review comparing midwifery led and other models of care, Sandall et al. (2016) provided descriptions of a range of different organizational possibilities. For example, with women booked with a team midwifery system receive care from several midwives in a clearly defined team, whereas caseload midwifery involves continuity of midwifery carer from one or two midwives (Sandall et al., 2016). Women who planned to give birth at the FMU had antenatal appointments from 36 weeks of pregnancy at the unit. The FMU, however, was not a conventional continuity model, because of the scope of activity taking place, however, the midwives overall considered it to be focused on building relationships like those found with case loading. Women who were cared for by this team in pregnancy could potentially give birth and have early postnatal care with the same team and have known their intrapartum midwife beforehand.

Though the FMU webpage defines it as being a facility primarily for the use of women expecting straightforward course of labour and birth ('low risk') for a public audience, the recommendation contrasted with the reality of relative flexibility. Where categories of intermediate risk applied to particular women, including well controlled gestational diabetes, and confirmed Group B Streptococcus infection (where intrapartum intravenous antibiotics were recommended), such women could be accommodated by having individualised plans of care developed with either the consultant midwife or obstetrician based at the host Trust, another example of the relationship with the wider service.

The referral process for the FMU was also based on the 'opt-in' approach. Thus, community midwives were relied upon to present information about the FMU to women when discussing potential place of birth. During data collection at the FMU it became clear that midwives were not confident that the service the FMU offered

was being made available by other community midwifery teams, particularly when the host NHS Trust opened a new alongside unit, thus affecting the numbers of women using the FMU. In short, the FMU midwives believed that the new unit was favoured both by the Trust and other community midwifery teams. Consequently, women not booked for antenatal care with the FMU midwifery team were not receiving information about their service.

The FMU team consisted of Band 6 and Band 7 midwives, maternity support workers, ward clerks and student midwives; all except the ward clerks worked 12-hour shifts. As with the AMU, a consultant midwife provided overall leadership for the unit. All midwives ran antenatal clinics through the network of local GP surgeries and carried out post-natal home visits, on foot, or by electronic bicycles supplied by the employing NHS Trust. Each midwife provided cover for the on-call rota twice a month and was rostered to work regular intrapartum care shifts.

It was noticeable at the unit that the staff did not wear uniforms, even whilst looking after women in labour. This may say something about the image they wanted to portray to women, or the ideas they wanted women to have about them. They did, however, wear the usual protective equipment common in clinical areas (aprons and gloves). Midwives discussed being diverted to the obstetric unit to work (approximately 3 miles away), at times of business or staff shortages, usually necessitating a journey by public transport or bicycle.

During the period of data collection, the number of senior Band 7 midwives decreased significantly from 10 to four. The original quantity of senior midwives had been a desirable feature of the unit. The distance, though small, from the obstetric unit placed value on a critical mass of experienced midwives being present to assist with the operation of the birthing unit, ensuring timely decisions were made, and supporting staff who were junior or less familiar with the ways of working. In addition, from the outset of the fieldwork, it became apparent that the relationship of the FMU with the link obstetric unit, and Trust management was

problematic. This had consequences for the number of women using the FMU for intrapartum care who were not from the local area, and therefore, recruitment to the study.

6.3 Participant characteristics

A convenience sample of 15 midwives was interviewed across both cases: 8 from the AMU and 7 from the FMU. Interviews lasted from 21 minutes to 1 hour 25 minutes. All interviews took place within work hours, at the respective units where the midwives were employed. There were three observations of midwifery practice: 1 at the AMU and 2 at the FMU. The intention had been to interview midwives following the observation of their practice. For the 4 midwives concerned (two midwives provided care during one of the labours), the researcher was able to interview 1 midwife after the observation (AMU case). At the second case (Case 2 FMU) 1 midwife was interviewed prior to the observation; post observation the midwife went on long term leave. For the second labour observed in the FMU, neither midwife was available afterwards (one midwife went travelling abroad, the other was not available during the time of the research cycle). The labours lasted 6 hrs, 2hrs and 15 minutes, and 1 hour and 5 minutes, and the entirety of each was observed. Neither of the 4 midwives had met the women beforehand.

The participating midwives from both AMU and FMU were predominantly NHS Band 6 midwives with varying degrees of experience, with a small number (n=3) of

Case 1 (AMU									
Midwife (MW) Participants & numerical code	MW 1.1	MW 1.2	MW 1.3	MW 1.5	MW 1.6	MW 1.8	MW 1.9	MW 1.10	
Interviewed? Yes/No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Practice observed? Yes/No	No	No	No	No	Yes	No	No	No	
Code for women consenting to labour observation					W1				

Case 2 (FMU)									
Midwife (MW) participants & numerical code	MW 2.2	MW 2.3	MW 2.7	MW 2.8	MW 2.9	MW 2.11	MW 2.12	MW 2.14	MW 2.15
Interviewed? Yes/No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	yes
Practice observed? Yes/No	No	No	Yes	No	Yes	No	No	Yes	No
Code for women consenting to labour observation			W3		W2			W3	

Table 6-1 Details of participants' contributions to study

NHS Band 7 midwives also included. Band 7 midwives had additional team leadership roles. The research protocol specified that midwives who were NHS Band 6 or above (denoting experience) with at least 6 months experience working in an MLU, were eligible for inclusion; these criteria were satisfied for all the participants.

Case 1 (AMU									
Midwife (MW) Participants & numerical code	MW 1.1	MW 1.2	MW 1.3	MW 1.5	MW 1.6	MW 1.8	MW 1.9	MW 1.10	
Interviewed? Yes/No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Practice observed? Yes/No	No	No	No	No	Yes	No	No	No	
Code for women consenting to labour observation					W1				

Case 2 (FMU)									
Midwife (MW) participants & numerical code	MW 2.2	MW 2.3	MW 2.7	MW 2.8	MW 2.9	MW 2.11	MW 2.12	MW 2.14	MW 2.15
Interviewed? Yes/No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	yes
Practice observed? Yes/No	No	No	Yes	No	Yes	No	No	Yes	No
Code for women consenting to labour observation			W3		W2			W3	

Table 6-1 provides details about midwife participants for each case, whether they were interviewed and/or had their practice observed. All participants (midwives and women) were given an identifying code. Conducting semi structured interviews enabled the researcher to explore midwives' perspective about the components of midwifery led care, and therefore what they considered to be defining attributes, as well as their opinions about how they were enacted. Observing midwives' care for labouring women gave more insight into key aspects of midwifery practice with respect to the defining attributes.

6.4 Cross case results for defining attribute themes and its sub themes

Full descriptions of the original defining attributes have been given in Chapter 2, and have been reproduced as follows:

- The midwife is the lead professional and acts as an autonomous practitioner
- Midwifery led care is associated with a particular ethos: the belief that childbirth is a normal life process. Midwifery led care encompasses a belief in women to give birth physiologically. Furthermore, midwifery led care involves promoting normality and taking account of women as individuals
- Midwifery led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models (abbreviated in Figure 1 to 'supporting and trusting relationships')
- Midwifery led care is women centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers (abbreviated in figure 1 to 'women focussed, individualised, women as final decision makers').

Defining Attribute Theme 1	Defining Attribute Theme 2	Defining Attribute Theme 3	Defining Attribute Theme 4
The midwife is the lead professional and acts as an autonomous practitioner	Midwifery-led care is associated with a particular ethos: the belief that childbirth is a normal life process	Midwife led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership	Midwife led care is women centred and meets women's individual needs: There is recognation that women's choices should be respected and that they are the final decision makers
Leading care through expertise	Knowing and understanding normality	Relationship	Being Responsive
Advocating for women	Balancing action and no action	Communicating	Making decisions about care
Problematic autonomy			

Figure 6-1 Defining themes and attribute themes

Each of the defining attributes themes will be discussed in detail below. Descriptions of the theme adopted from the literature review of the concept analysis are also provided. The sub-themes equate to the different ways defining attributes are enacted in midwifery led care. Illustrations have been incorporated into this research study. These pictorial figures were created simultaneously by the researcher during the observations of births. They represent instinctive and spontaneous expressions of the researcher's interpretations, capturing real events of midwifery care, and allowed for an enhanced expression of what was being researched and witnessed. As Janis et al. (2020) assert, the use of art has the potential for enhancing the understanding of the research context.

6.5 Defining attribute 1: The midwife is the lead professional acts as an autonomous practitioner

6.5.1 Description of the first defining attribute from literature review

Within the literature review (Chapter 3) the first of the defining attribute themes describe the importance of the concepts of leadership and autonomy, where midwifery led care was associated with midwives who had the authority and ability to make decisions about the care given to women. Autonomy is considered a central concept. Midwives worked independently of other related practitioners (such as obstetricians and nurses), and under their own responsibility. In midwifery led care settings midwives were able to practice with a level of autonomy not usual in obstetric led care settings. Consequently, if there was input from other professionals, such as obstetricians, it is because the midwives had solicited it. Midwives' autonomy may have been limited by the fact that the medical model of care, over which obstetricians presided, was dominant within maternity services.

6.5.2 Description of sub-themes

The data related to this theme came from both cases, and within the cases, from both observation and interview. Data was organised into three sub-themes of leading care through expertise, advocating for women, and problematic autonomy. The sub-themes reflected the significance of the idea of autonomy for midwifery practice and the complexity of the midwife's position in being the lead professional and exercising autonomy. Extracts from the data are incorporated to enhance understanding and illustrate where there was convergence with and divergence from the defining attribute theme Figure 6-2

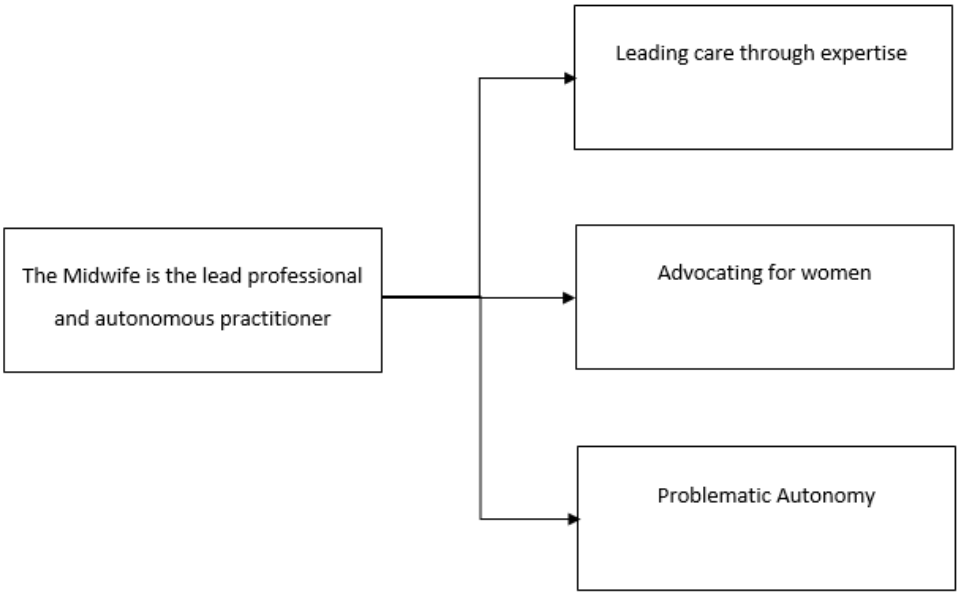

Figure 6-2 First defining attribute theme and sub-theme

6.5.3 Leading care through expertise

By definition, the accepted practice within the research cases was that midwives were the lead professionals in the care for women. Because they were the lead professionals, if labour and birth remained within the limits of normality and untoward events did not occur, there was no duty to involve other professionals. 'Leading care through expertise', therefore, was demonstrated by midwives being the principal professionals caring for the women who used the two midwifery led unit cases. For two MLU midwives, one from each of the research cases, the positions they occupied with respect to leadership were expressed by the following words recorded during interviews:

"So, for me that means that the midwife is very much, is taking the lead in care but only in the sense that they're the ones that would go in and kind of be with woman, make the assessments, and decide as and when maybe other people needed to come in for help and support or, em, if she needed to kind of change the setting." FMU MW 2.12

"Therefore, they don't need the input of doctors where it's not necessary. So, they'd be cared for, intrapartum, on arrival, all the way through […] until they deliver, by a midwife" AMU MW 1.9

It was important, also, for midwives to have had well-honed skills in making decisions about women's care in settings where they were the sole professionals. They needed to be able to anticipate what might happen and make plans in advance.

"I love the decision making process that midwives have when we don't have doctors around […] Midwifery led is also being in a room where you are the only expert in the room making clinical decisions and that becomes very sensory based, very intuition based […] you're decision making all the time on a midwifery led unit. There's no emergency buzzer where someone's gonna save you. So, it really tightens up your skills. And it makes you make decisions […] far before you would normally make decisions" FMU MW 2.15

'Leading care through expertise' was observed by the researcher in midwives taking charge of and having responsibility for organising and carrying out clinical care. Midwives were observed making decisions about what care was needed, having the ability to react to events as they occurred. It included midwives reassuring themselves that labour was progressing, the woman and her unborn baby were well, and that the labouring woman was made aware of the reassuring picture. The researcher was able to observe the entirety of three labours. It was notable that Midwives did not make their leadership or authoritative position (i.e., the fact of being in charge) explicit to women. In an example from the AMU observation of practice, the midwife talked to the researcher about her desire to carry out a vaginal examination at 13.00hrs that day; she made the request to the woman several times before it was achieved:

"MW 1.6 told me of her plan to examine the woman PV (per vaginem examination) at 13.00 hrs so when we entered the room it was with that plan in mind." observation AMU MW 1.6, W1

"13.25 hrs: the woman is now back in the room. The midwife comes to the desk and begins to write in the clinical notes. She mentions the vaginal exam again, suggests the woman returns to the bed. This does not happen immediately." Observation AMU MW 1.6, W1

Sometime later the midwife broached the topic again:

"13.50 hrs: the midwife starts a conversation: ' What I would like to do now', ' How would you feel about an examination now?' […] the woman is in agreement about a vaginal examination, so preparations are made." Observation AMU MW1.6, W1

A variety of practices was undertaken to ensure that progress and wellness were present: assessing blood pressures and other vital signs, checking the fetal heart rate, or intently examining the colour of amniotic fluid on a woman's sanitary towel to rule out the presence of fetal meconium, a sign of possible fetal hypoxia.

"The woman is standing now, so the midwife is kneeling by her side with the hand-held Doppler transducer on her abdomen, listening to the fetal heart. The midwife steadies the woman in the process by a hand in the small of her back. The midwife smiles at the woman when the transducer picks up the sound of the fetal heart. 'Perfect' she says." Observation AMU MW 1.6, W1

"The midwife takes the used sanitary towel from the woman and walks to the vicinity of the window where there is some light […]. The midwife checks the pad under the light. She explains that she wants to show a colleague the pad, to have a second opinion, about the colour of the water, she tells the couple that it looks a bit yellow […]. The midwife is back in the room. She explains that on the pad, in better light, she has seen a tiny bit of light coloured 'poo'. She talks about what this means […] she suggests that we carry on what we are doing. By this she means no change to the labour care." Observation AMU MW 1.6, W1

In the second example above, the midwife was observed consulting with her midwifery colleagues to come to a decision about care.

In leading care, midwives provided advice or instructions to women throughout labour, for instance, useful physical positions to adopt to help the fetus descend

into the birth canal, or the importance of drinking enough water. The following are two related extracts from observations of midwifery care.

"The midwife […] encourages the woman to put one of her knees up whilst she is in the kneeling position: 'put this knee a little in front'. With the next contraction the midwife encourages the woman with: 'remember, open your mouth. Let it go when you feel pressure.' " Observation FMU MW2.7, W3

"The midwife also moves towards the counter and asks: 'do you want a pillow?'. She takes a pillow from the bed and places it under the woman's head, as it rests on the counter, so she can relax into her stance. 'Do you want water?' the midwife enquires […] [The] midwife fetches a glass of water, saying 'Entonox makes the mouth really dry'." Observation FMU MW2.7, W3. See Figure 6-3 Illustration from field notes

Figure 6-3 Illustration from field notes
Supporting positions for physiological birth

The midwives had an agenda of what assessments they wanted to carry out. They undertook all the care over several hours, including watching the women and responding to events of the labour. The skills they used to carry out the assessments

denoted expertise. Essentially the midwives 'knew what to do' to care for women, and through their actions represented themselves as lead professionals.

"The midwife is up to take the woman's pulse and temperature. She is asked when the baby is coming and responds that she could re-examine the woman again at 6 o'clock." Observation AMU MW 1.6 W1

"After writing more in the notes at the desk she returns to the woman. This goes on for some minutes: checking with the torch during contractions, massaging legs, encouraging words, writing notes." Observation AMU MW 16 W1

"The woman gets onto her side on the bed, with the first midwife supporting her to elevate her left leg when she is bearing down. The second midwife suggests to the woman a sanitary towel soaked in warm water for her perineum, and the first prepares one, explaining to the woman that it might help with the haemorrhoids. She places the sanitary towel against the woman's perineum" Observation FMU MW 2.7 & 2.14 W3

Several of the midwives interviewed considered that experience was an important part of midwifery expertise. It added to midwives' understanding about how to interpret what was happening in labour, and knowledge of what to do. When asked about key aspects of leading care, one AMU midwife talked about the value of working with other experienced midwives.

"Experienced people, experienced midwives [...]. Cos, we had a time when we had […] preceptors[24] that were part of the numbers and it's really hard to be in charge of the unit, to be in charge of the other midwives, to be in charge of everything. Every phone call. Everyone that goes through the door, and you can't count on the other person if you've got an emergency." AMU MW 1.3

[24] Preceptorship midwives are newly qualified professional who undergo a preceptorship programme of structured support, to help them adapt their knowledge into everyday practice.

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Another AMU midwife identified experience as the most important factor, when discussing reasons for successful midwifery led settings:

"Number 1: you actually need experienced midwives as well. Because, you know, inasmuch as it's simple, you need […] experienced midwives so that they can bring their knowledge from […] whatever background they are coming from into this." AMU MW 1.5

Experience was necessary for midwives to develop confidence in childbirth being straightforward; confidence did not come from reading midwifery text books:

"Trying to capture it and explain it is absolutely impossible until you've been doing it yourself for a few years and then it's almost like you have this weird epiphany of 'right, this is what is happening' 'this is what goes on'. And in yourself as a midwife you have to gain that trust in birth. That's something that you can only do and experience. No Mayes or Myles is going to tell you how to do that. You have to just do it." AMU MW 1.8

One FMU midwife explained the advantage of having experienced role models in the midwifery team and the implication for developing the practice of others:

"So, when a new midwife comes and I see her doing something … I'm happy to say 'you know what … you cut the cord way too fast' or 'you took the baby out of the water too fast. Just slow down, slow down!' And midwives who have come … (here) … are really open to that … And then that really encourages midwives to … when you watch more midwives that are doing so much, you gain so much … you don't have the responsibility but you're watching … excellence. You're watching midwives that have done it for years and have that openness and that kind of intuition, working." FMU MW 2.15

Experience was also important because it meant other colleagues could trust the level of care being given to women. The following extract shows a connection, in the AMU midwife's perception, between experience and dealing with emergencies such as shoulder dystocia and post-partum haemorrhage (PPH).

"For me an experienced midwife is a midwife who has seen a shoulder dystocia, has been involved in a PPH [...] experience in terms of she's got the knowledge of what's happening when a woman delivers " AMU MW 1.3

Experience was also significant because it improved practice and confidence in making women-centred decisions rather than organisation centred ones. This FMU midwife explained how her practice had evolved through experience.

" I was more junior than I am now…I felt the pressure that I needed to convince more the woman to achieve the choice that the doctors of the system wanted to. Whereas now, it's more like, I discuss it and then if you don't want it it's your choice as long as it's documented you understand the risks and the benefits and why we are suggesting this, it's just entirely up to you.' FMU MW 2.11

6.5.4 Advocating for women

Evidence from interviewing midwives at both research sites demonstrated that they recognised they had a responsibility to advocate for women: speaking up for them and supporting the choices they made. Therefore, through being women's advocates, midwives were able to demonstrate their leadership position. The idea of advocating for women was related to the overarching defining attribute theme because it was through being in a position to plan and make decisions about the way maternity care was provided that midwives were able to successfully speak up for women in situations where opinions differed.

The advocacy consisted of midwives aligning themselves with women in circumstances where others were involved in the care, either family members or professionals, and there were competing views about what should happen in during labour. In situations of family members not being on board with what women wanted, midwives had to be prepared to represent the woman's case to them.

"***But also knowing when to say 'actually, no, we have to … support the woman in what she wants', trying to make sure everyone in the room is … supportive of the woman and that we're all on the same page [...] that can often be just reassuring birth partners so that they're not scared anymore and that they can support the woman with her choices***." FMU MW 2.12

The choices women made could conflict with what was desirable. The philosophy of care at the midwifery led units included doing everything possible to encourage physiological birth, as expressed by one AMU midwife. If labouring women desired an option that could interfere with physiology there was still an obligation for the midwife to advocate for the woman.

"***It's her body, you know, it's her choice, and we just need to provide the service, we're not here for ourselves. We're here to provide something that can allow the woman to be what she wants […] I think that our philosophy really, is to do everything we can to promote normal physiological birth. Er, with the most support possible. And […] be an advocate for a woman as well […] if she suddenly, wants to go labour ward and have an epidural, that's fine, let's go there, and let's have it as quickly as possible as we can***" AMU MW 1.3

Advocacy was also embodied in the way a midwife protected the woman's wishes and choices when other professional colleagues, whether internal or external to the midwifery led unit, were involved, thus reducing the need for the woman to explain herself to multiple people.

"And then also I think a big part of that is other staff. So, advocating doesn't have to necessarily be [that] people are gonna disagree with you, it might just be explaining the situation to other members of staff so they understand and they don't come in, and kinda say the same things or question, you know" FMU MW 2.12

"For example, if a neonatal doctor comes in but actually everything's ok, it's ok to say to them, 'oh no, they wanted to do skin to skin and delayed cord clamping' rather than just because of the hierarchy in labour, automatically let them do that. There doesn't even have to be a battle over it, you're there just to communicate what the woman wants, have her listened to, be the voice." FMU MW 2.1

Midwives also described situations where being the woman's advocate meant being assertive in getting the right care when they needed to escalate the care to other professionals.

"If you know that there's something not right especially with the baby's heart rate or there's a delay, or actually, you know, you want somebody else just to come in and, and assess the situation with you. Like making sure that you are there saying ' no [...] someone needs to come now' you know obviously you have to be

professional but there comes a point where you should escalate things rather than, just like being 'ok [...] yeah, if you're busy I'll just wait' "FMU MW 2.12

There were occasions where standing up for a woman's wishes might compromise safety, thereby putting a midwife in an uncomfortable position. One FMU midwife spoke of such an occasion at interview: where the midwife herself believed that an MLU was not a safe option for a woman, continuing to advocate for that woman meant that the midwife needed support and advocacy for herself. She needed someone to 'have her back'. In this instance, a woman had suffered a post-partum haemorrhage (PPH) after giving birth but declined to be transferred by ambulance to the obstetric led unit.

"Someone having your back is important [...]. An example is a woman with borderline mental health problems who had a PPH of 1.4 litres and refused to be transferred to the hospital. There was a clear plan in place, the plan was followed … (but) …the birth centre has to be safe for women and babies, it's not just about women's wishes: there are three parts to it, women, baby and midwife, all have to feel safe." FMU MW 2.2

For another AMU midwife, the perception of lack of support structures meant midwives could be left in unnerving situations.

"The woman can choose to birth where she wants to give birth, ok, so what needs to be in place is certain structures, so if that woman presents whilst you're on duty and you don't feel confident to give her labour care for whatever reason, then there's something in place for you. Now technically there's meant to be, but there isn't in reality, yeah? So, that can then leave the midwives feeling really unnerved, yeah? 'Oh god I hope she doesn't come in on my shift' " AMU MW 1.10

It is noteworthy that midwives were hesitant about being supported to affirm women's choices when childbirth became complicated and women declined transfer. The AMU clinical guideline (Doc 1.02) specified the level of support needed when complications arose:

"When transfer to the labour ward is advised but the woman declines, during the day, one of the Consultant Midwives or Matron for the community and Birth Centre or the manager on call should be contacted. At night and weekends the Supervisor of Midwives should be called for support and advice and to attend if necessary" Document 1.02 (AMU research site, 2015)

The guideline was clear in specifying the depth of support midwives might need in such situations. The wider maternity team of senior midwives and obstetricians were expected to come to the assistance of the birth centre midwives. Birth centre midwives were not necessarily convinced, however, that the supported team response: ***"(if) ... the woman continues to decline transfer to the labour ward, a senior obstetrician team should continue to support the midwives providing care …" Document 1.02 (*****AMU research site, 2015)** would actually take place.

6.5.5 Problematic autonomy

The data contributing to this sub-theme reflected the ambivalent nature of autonomy. Autonomy, in itself, was a contested or problematic issue. There was a variety of views on whether it was truly an attribute of midwifery led care, and if so, which features of autonomy were desirable. Evidence came from both interview and observation of midwifery practice. Firstly, the more conventional one where the fact of midwives being autonomous practitioners was not questioned and considered intrinsic to a midwife working in midwifery led care. This was expressed during interviews as meaning the following:

"Me as the midwife is the sole care giver and would be the main person to make any decisions at that moment … without the input from the obstetric team.' AMU midwife 1.6

"So, the autonomy in the environment of the labour is, I think […] related to your experience. Because [the] more experience you have, [the] more autonomous you are, no? " FMU MW 2.9

In the second of these examples, autonomy was also positively linked to experience. In another example, the midwife commented on her first experience of working in a completely midwifery led unit.

" [The experience is] fantastic, fantastic, for the midwife; at least you are able to explain more about what we've learnt really [laughs], because we are autonomous practitioners you are able to bring out your skills, you know, without much interference from the doctor. I think it's just wonderful" AMU MW 1.5

The FMU's public-facing messages about birthing unit reinforced this idea of skilled expertise.

"Our team of expert midwives are trained in active birth techniques and experienced with waterbirths. We can show you how best to use birth pools, beanbags, mats, balls, and stools to help you manage your pain." Document 2.02 (FMU research site, 2014)

All three observations of practice verified ways that midwives enacted autonomy. It arose from being the lead professional tasked with providing care, being able to negotiate what happened in labour, and make decisions without seeking or needing input from obstetricians.

In observing midwifery care, midwives were seen to be benignly fulfilling their roles without necessarily and obviously asserting their autonomous position. The midwives were seen to be working independently of other professionals in planning and executing care, taking responsibility, and making judgements based on their knowledge. There was no mandatory obligation to confer with colleagues about the care they wanted to deliver.

By contrast, a more critically reflective understanding of autonomy was gleaned from some of the midwife interviews. There was an opinion that there were limits to the level of independence possible whilst working within the National Health Service (NHS). The NHS was seen as having a restraining effect on how midwives worked with women and negotiated how women's wishes were addressed. For this midwife, despite being an NHS employee, working away from the vicinity of doctors and co-ordinating midwives from an obstetric-led labour ward increased the possibility of being autonomous.

"I'm quite realistic in that true autonomy would be that you're working with just you and that woman and whatever her wishes are. But when you're working within the NHS in a Trust, you have got to be mindful of the fact that you are working under a contract to the Trust [...] In a way you can be more autonomous (in an MLU) because you haven't got doctors and co-ordinators rubbernecking in your room and asking what's going on." AMU MW 1.10

The sentiment was mirrored in the opinion expressed by another midwife, who considered that autonomy came from not being bound by specific clinical guidelines.

"In the birth centre, well you are autonomous […]obviously is more than [in] the hospital in the labour ward because you are working one to one and you are not related to any specific protocol or policy to follow because your woman is not ill. So, you don't have not a risk factor. So obviously you have […] you have a space to move (by space here means scope) so your autonomy is a consequence of the [midwifery] led care." FMU MW 2.9

When asked how autonomy was effected in practice, an AMU midwife offered the following:

"You assess this woman and […] as you said, if the woman doesn't need VE you don't, it's about natural birth, and it's individualised, you can deviate from the protocol a little bit as long as it is safe, bringing [in] the woman's wishes. So, that's why you bring in your skills and your practice into it." AMU MW 1.5

One AMU midwife refuted the importance of midwives being autonomous as individuals. Instead, it was desirable for the midwifery profession as a whole to assert its position as an autonomous 'movement' of professionals, but not as individual midwives in an MLU.

"So, for me that means that the midwife is very much, is taking the lead in care but only in the sense that they're the ones that would go in and kind of be with woman, make the assessments, and decide as and when maybe other people needed to come in for help and support" AMU MW 1.8

She went on to explain:

"***Because I'm not autonomous, actually, I work in a sisterhood almost. As a movement we're autonomous, and that's what I really like about midwifery. And actually, the ethos is respectively [sic] observing childbirth, not coming in, not***

pulling baby out, we're not playing God with these people. All we're here to do is assist the transition for that mother and that family at that time. So, autonomy, for me, is all about advocating for the woman, that's fine. But as a practitioner, as an individual, it's of no importance to me to make my own autonomous decisions." AMU MW 1.8

6.5.6 Summary

Each of the sub-themes around which the empirical data was organised supports the legitimacy of defining attribute i.e., midwives being lead practitioners, with a qualified view on autonomy. For 'leading care with expertise' midwives were observed being the primary professional in the midwifery led care settings. Because of the nature of the organisation of the midwifery led care settings, they were the sole professionals in residence. They demonstrated expertise through having the knowledge and skills necessary to organise and carry out care.

Similarly, midwives demonstrated understanding of the complexities of advocating for women, with suggestions of how this role was enacted in practice, in representing women's wishes to birthing partners or other professionals. In the empirical data midwives commented on their own need of advocacy in order to fully support women to be cared for under midwifery led care.

The data collected that related to autonomy mirrored the complexity from the defining attribute description. Autonomy, though considered by some midwives to be an unquestionable feature of midwifery led care, was constrained by being part of the wider organisation of the local NHS maternity service. However, midwifery led care gave a greater opportunity for midwives to be autonomous practitioners when compared with other settings such as an obstetric led labour ward.

6.6 Defining attribute 2: Midwifery led care is associated with a particular ethos; the belief that childbirth is a normal life process

6.6.1 Description of the second defining attribute from literature review

The second defining attribute theme relates to the central belief that the process of childbirth is a normal life event rather than an inherently pathological one. The literature review identified two contrasting issues. The first was that midwifery led care supported the process of birth through practices such as ensuring care was right for individual women (i.e., not standardised), and refraining from intervening to hurry it up, thereby not disturbing the physiology. Also significant was midwives' underlying clinical knowledge and skill to judge when either inaction or intervention was warranted. The second issue was that midwives, rather than being confident in the likelihood of physiological birth, were influenced by the overall risk averse nature of intrapartum care. The risk averse nature of intrapartum care refers to the fact that most intrapartum care takes place within obstetric led units. The effect that the dominance of obstetric care has on childbirth being viewed risky has been discussed in Chapter 1.

6.6.2 Description of sub-themes

The data related to the second theme came from both study cases, and from interview and observations. It was organised into two sub-themes: knowing and understanding normality, and balancing action and no action. The complexity of the data resulted in the second sub-theme having several related descriptors. These descriptors enhance the explanation of each sub-theme. Figure 6-4 displays the typology of sub-theme and category for this theme. Extracts from the data have been used to increase understanding and show where there is convergence with and divergence from the defining attribute theme.

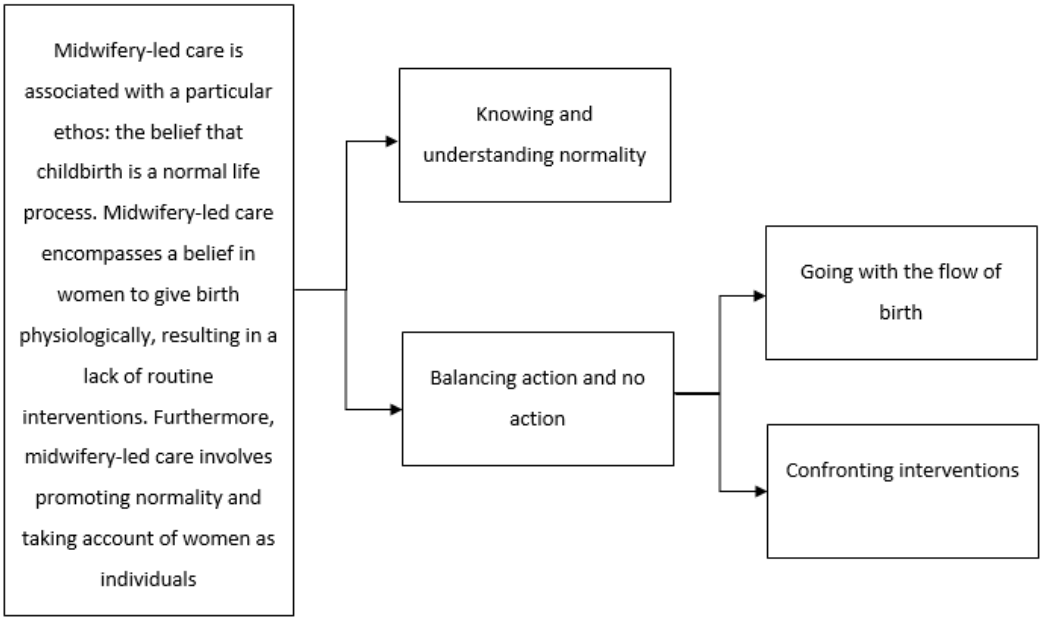

Figure 6-4 Second defining attribute theme and sub-themes
Knowing and understanding normality, balancing action, and no action.

6.6.3 Knowing and understanding normality

The first of the sub-themes signified midwives having knowledge of childbirth in order to verify progress in physiological labour. The knowledge gave them belief and confidence in women's ability to achieve normal physiological birth. The knowledge also stemmed from having a world view or ethos that was supportive of the midwifery led care model. For some, the world view of the midwife was axiomatic for physiological labour and birth; the usual paraphernalia, or 'fancy stuff' that enhanced the environment of the setting was unnecessary. The first midwife's statement that key to normal physiological birth was 'a dark space and a good midwife' contributes to the title of this thesis.

"You don't need any of this fancy stuff, you need dark space and a good midwife, and she'll do it. So, lighting, temperature control, that's fairly important. Birthing aids, you don't need no fancy pool or birthing chair, really; it's all about the ethos of the midwife." AMU MW 1.8

"It's an ethos about believing in women, normality, and not medicalising it." AMU MW 1.6

"So, I think that our philosophy really, is to do everything we can to promote normal physiological birth […] with the most support possible." AMU MW 1.3

The belief in women being the agents of childbirth was reinforced in the information given to women planning to use the AMU. The tone was informative and congratulatory: labour was normal, women could manage early labour with rest, walks and distractions. The advice given favoured homely and social measures that affirmed women's capabilities (Document 1.04, AMU research site, undated). Knowledge of normality, or physiological birth also allowed midwives to detect if problems were developing in the labour. Midwives expressed their awareness that women's fear, inability to relax, or being distracted by other responsibilities, could antagonise physiological processes of labour, or make them stall. In this sense, midwives worked with normality. For one FMU midwife, it was important for a midwife to believe that childbirth was a fundamentally normal event.

"When you have an event what should be part of your normal life what is birth [and] you act as [though] that is an illness, […] a midwife [who] is acting this way, I think is very difficult the concept to keep [birth] normal and said the birth is an event normal for a [...] healthy woman." FMU MW 2.9.

There were several other issues connected to midwifery knowledge, the sub-theme displayed some midwives' beliefs in intuitive knowledge, respect for 'old' knowledge passed down from other midwives or personal experience. Such forms of knowledge were used in their practices, and in making clinical decisions. Ideas about knowledge were expressed in the following excerpts from 3 midwives about the skills they mobilised in caring for women:

"It's not even research as such, it's just old knowledge that's been probably passed down from […] you may remember, or you may if you've had children yourselves […] it might not be in the policies […] they're not things that you've learnt in a book, but they're things that you've learnt along the way" AMU MW 1.10

"A lot of it is intuitive, and we teach midwives here to be intuitive […] It's a deeper conversation and you want to pull that out of a junior midwife or someone who isn't as au fait with [midwife led care] to say, 'what do you feel', 'what do you feel should happen next' and base it directly on intuition" FMU MW 2.15

"That person's coming in in early labour and that intuition that […] something just wasn't right […] although you've tried to do all the different things. And that again is decision making with that woman saying, 'we've tried that all, and I think there must be something else going on and I think it's best to move to the other unit.' " FMU MW 2.15

"Is also to have a sense […] have that feeling of sometimes with no words what the people need. So, its listening, looking, how you look, it's the communication, it's the touch, because obviously I think also the touch, how you, maybe you give your hand or put your hand to the woman." FMU MW 2.9

Nevertheless, the following extracts from interview and observation made it clear that midwives did also regard clinical guideline recommendations as sources of knowledge, albeit some showing reluctance to have a blanket approach to looking after individual women. Midwives used the words 'guidelines' and 'policy' interchangeably.

"So, in terms of actually giving care we'd be following the low risk intrapartum care guidelines that are on our intranet […] that also goes along with the water birth policy." "You're kind of armed with the tools of your guidelines, which, you know, they're ingrained in our heads […] so it's kind of a bit autopilot." AMU MW 1.9

Later in the interview, the same midwife also suggested that it was not always useful to work according to guidelines, particularly with respect to women who had given birth before (referred to as 'multips'; women labouring for the first time are referred to as 'primips'):

"We follow the guidelines because […] we're here in the Trust […] however, I do believe that maybe we should not do that. We know from multips coming in, maybe primips might be a different kettle of fish […] I just think 'leave them well alone. Let their bodies do what they're doing" AMU MW 1.9

Another AMU midwife discussed the place of guidelines and policies when making decisions about care in the midwifery led environment:

"Well, we have our guidance, and that's quite important […] it's about what happens, what intertwines with their birth plan and also the policies" AMU MW 1.6

Midwives were observed incorporating specific guideline recommendations into their practice. The following are instances from both study cases of midwives adhering to recommendations from national guidelines[25]. National guidelines recommend that the fetal heart (FH) be auscultated, or listened to, with an appropriate instrument every fifteen minutes in the first stage of labour and every 5 minutes in the second stage of labour (see glossary for definitions of the stages of labour). Recommendation also exist for determining the interval for auscultating the FH in labour, aiming to do so when a uterine contraction has ended. In addition, with respect to vaginal examinations there are recommendations that suggest introducing the idea of a vaginal examination 4 hours after the previous one.

"The MW tells the couple that she will listen to the FH every 15 minutes now." Observation AMU MW 1.6, W1

"When we're auscultating, immediately after that contraction […]. So, you're auscultating for that minute. That's the gold standard; immediately following that contraction […] auscultate every fifteen minutes, when she looks like she's in second stage, do it every five." AMU MW 1.8

[25] The recommendations from the National Institute of Health and Care Excellence (NICE) for caring for healthy women in labour are widely used in UK maternity services

"She introduces the idea of examining (vaginal examination) AM again at 18.00 if nothing has yet happened." Observation AMU MW 1.6 W1

"The woman still uses Entonox [for the contraction], breathing hard. 'May I have a listen when that is done?' 'Is that ok?' "Observation FMU MW 2.7, W3

Despite their habit of referring to guidelines and taking their recommendations into consideration, there was a sense that midwives found them burdensome. Adhering to guidelines (referred to here as protocols) might interfere with women's choices or impose unjustified restrictions.

"In an environment where you have to follow protocol, you have to remember the protocol, you are not remembering what the woman's choice is." FMU MW 2.9

"Time constraints, having to stick to the guidelines […]. We know if women had a bit of extra time, they would have done it rather than having a Ventouse or occasionally a forceps." AMU MW 1.9

In addition, there was a belief among some midwives that guidelines did not really fit in with midwifery led care, or could be sidestepped. (The first example comes from an FMU midwife who chose not to be audio-recorded and whose interview was summarised from the researcher's notes).

"The fact that at the FMU there was the possibility of not sticking to protocols, of being more flexible […] compared with the hospital." FMU MW 2.2

"Obviously you have to work within the set of guidelines but if there is a little bit of deviation and the woman wants to come in here, we cannot say she is not going to have her care here because she has choice. As long as you have made her aware of the risk" AMU MW 1.5

"You don't say […] this is what [is] supposed [to happen], you can deviate from the protocol a little bit as long as it is safe, you know, bringing the woman's wishes" AMU MW 1.9

In both research sites, midwives were surrounded by evidence of their connection with wider maternity service. They were subject to the same overall governance and safety procedures (for example, infection control procedures, fire policies and

information governance), however, their intrapartum care guidelines had been produced specifically for the midwifery led environments. The guidelines supported the midwives' inclinations for making the MLUs accessible places for women with 'a little bit of deviation', and identified 'intermediate' (FMU) and 'amber' (AMU') risk factors. Intermediate/ amber risk factors required women to consult an obstetrician or clinical midwifery leader before accessing the MLUs (Document 1.02, AMU research site, 2015; Document 2.03, FMU research site, 2017). However, there were many instances where, rather than contemplating clinical guidelines, midwives referred to their knowledge of physiology to shape the care given to the labouring women.

"So, from my point of view is just trust in the physiology, trust in the woman work […] try to keep normal with all your knowledge and tools what you have." FMU MW 2.9

The importance of **"understanding the normal process, understanding the latent phase, OP**[26] **positions"** (AMU MW 1.6) was emphasised, with strategies to support women in coping being suggested:

"***mobilising, eating, sleeping, going in the pool, going in the bath, mobilising eating […] sleeping, in a round, back-rubbing, like in a round" (AMU MW 1.6).***

In particular, the effects on birth of the hormone, oxytocin, and the impact of women's physical positions and movement in labour, were stressed. The following passages display the various tactics used to maintain and encourage low lighting,

[26] Occipito posterior positions are where the occiput of the fetal skull is in a posterior position in relation to the maternal pelvis. It is considered to be a malposition, making labours longer and more painful.

or support a quiet atmosphere, i.e., conditions that enabled the flow of women's endogenous oxytocin.

"***The midwife is still in her position in front of the woman, using the torch when contractions come, the room really dark now". "The room is quiet [only] muted voices from the television." Observation AMU MW1.6, W1***

At Interview two midwives explained how their actions reflected perceptions they held about the value of oxytocin. One midwife encouraged women to alter the lighting to their taste. The other took account of a factor that may interrupt oxytocin, i.e., anxiety, and strove not to leave the woman alone to avoid her feeling anxious about labour.

"So, you take them straightaway over to there (pointing in the vicinity of the door where the light switch is placed). 'Right: here's the lighting', I'd advise that nice low lighting really really boosts that oxytocin level and that's what we need. 'So, pop it on a lower lighting if you'd like to' " AMU MW 1.8

"It's about being there, I just think, and making sure she knows that she's not alone so she won't get anxious and hopefully the oxytocin will flow and things will move forward so that she births." AMU MW 1.6

As well as promoting oxytocin release, there was also acknowledgement from an FMU midwife about the desirability of the more primitive, 'irrational' part of the brain being mobilised in labour, hence the need to avoid unnecessary conversations.

"But I don't like to talk too much in the birth, so I will try to see how she reacts with her non-verbal cues […]. Cos I don't want her rational brain to […] be active. I want just the irrational part of the brain to be […] working more." FMU MW 2.11

These midwives were observed presiding over an environment that was virtually silent, a feature considered to assist in oxytocin release:

"The contractions and breathing through and moaning of the woman are continuing, the backdrop is a dark room with no other sounds but the air conditioning." Observation FMU MW 2.9, W2

"The room is silent in between the times that the woman is contracting. In fact, she closes her eyes and sleeps in between the contractions and the midwife sits silently while she is sleeping." Observation FMU MW 2.7, W3

Turning now to midwives' knowledge of different physical positions and movement in labour, midwives considered their own role in steering women towards physiological birth. They used their knowledge to make suggestions and give advice to women about actions that might have a positive effect on progress.

"I think it's really important to believe and to know that that [normal physiological labour and birth] is possible and most often optimum for most women, but, to have a really healthy understanding and knowledge and skills to understand when things begin to perhaps go off that path, and either to do things to help set it back on the path, because there's lots of, like, you know, midwifery led interventions that you can do and work with the woman on [...] that mean […] women still then have […] a normal birth" FMU MW 2.12

A more specific illustration was given by an AMU midwife of suggestions made to women when their labours 'tailed off' or slowed down:

"So, then they [the contractions] can tail off a bit […] we know that if we get the woman up doing like a Sumo walk and then squatting down. Or we get pasta, throw them on the floor [for the women to] pick them up" AMU MW 1.10

There were also occasions noted from observation that made it evident how involved midwives could be in encouraging women to take actions to maintain progress towards physiological birth.

"The midwife gets up from the bed where the couple are and where they can see her, she imitates a Sumo Warrior lifting one leg up then the next, and talks about how gravity helps." Observation AMU MW 1.7 W1

However, several midwives pointed out that though they had belief in normality, their knowledge also included awareness that labour and birth did not always progress physiologically. Midwives were responsible for judging when labour was deviating away from a 'normal' path. Additionally, midwives needed to be able to assess when it was not appropriate for the woman to remain on the MLU.

"Another feature of midwifery led care is the level of responsibility midwives have when they are the lead professionals; they need to have the knowledge to recognise when a situation goes away from normality. In labour there is a process of continuous assessment and any minute it can go off and midwives need to be able to recognise deviation." FMU MW 2.2

6.6.4 Balancing action and no action

The second of the sub-themes comes about because midwives are engaged in an exercise of continuously assessing women's labour. They make judgements about when to relax and accept events as they occur, and when to act and intervene. The data for this sub-theme has been divided into 2 descriptors: 'going with the flow of birth' and 'confronting intervention' (see Figure 4). The significance of the descriptors is that they correspond to the diversity of practices midwives use in looking after women in labour, explained fully below.

6.6.4.1 Going with the flow of birth

For one AMU midwife, the idea of *'going with the flow of birth'*, the first of the descriptors, mimicked what happened in television wildlife documentaries. She suggested how the concerns felt by television audiences about animals being pursued by their natural predators led them to will film crews to intervene. Similarly, midwives, might also feel a (misguided) desire to save women from natural birth.

"Midwifery for me is very much the same [as what happens in nature]. You are there to empower what nature is going to do, and what that woman's going to do. […] you're not there to direct her in anyway other than the route that she's gonna take […] so actually why don't you just step back, let mother nature do its thing, and let the women lead the care." AMU MW 1.8

Midwives going 'with the flow' meant that there was no need to act if the woman was progressing in labour. The midwife did not need to direct woman with suggestions about what they should do, even if there was something the midwife would like to see happen, such as a change in position. In this way the midwife was consciously passive. This position is illustrated by examples from interviews:

"Just allowing women to just have what's going on in their bodies to let it just do it […] what's coming naturally and encourage them […] all the top tips that we know that help labour along, being in upright positions, keeping the environment low lighting […] we do all of the kind of environmental things and empower the women' AMU MW 1.9

"But if you're doing it right then really all you are doing is observing." AMU MW 1.8

"And just comfort her but not invading her space" FMU MW 2.11

"Well, usually, I make a proposal and, for example, if everything's normal, if everything's going well, I'm not really asking for her to move or become active, I don't give any indication. I leave the woman actually follow what they feel to. And I'm just looking, I'm listening […] I am, in this way a passive way, no?" FMU MW 2.9

The phenomenon was also noted during the second of the FMU labours observed by the researcher.

"The woman says: 'I feel like pushing'. 'Do what you feel' responds the first midwife. 'I feel like pushing' the woman reiterates. 'That's fine' from the second midwife. 'But my waters haven't gone'. The first midwife then explains that her waters not having gone doesn't mean anything about how she is progressing." Observation FMU MWs 2.7&2.14, W3

'Going with the flow of birth' or being 'consciously passive' consisted of midwives watching and waiting until such a time as action was indicated.

"A lot of it is to put your hands behind your back and observe, because most of labour you observe." FMU MW 2.15

"She expresses the idea that the care that was offered to women at the FMU allowed midwives to really look at women, look at how they were behaving; women needed time, every woman was different." FMU MW 2.12

"In this environment you need to be able to wait the right time for taking actions, and be patient, and just talk maybe with the woman. Say: 'look, we need just to wait, because labour obviously is not something what we can really stress and push, but just give it time." FMU MW 2.9

The actions of watching and waiting also featured in observations of labour care.

"The room is quiet, apart from usual sounds. Waiting is going on. MW is on a chair at the desk. More waiting." Observation AMU MW 1.6 W1

"The midwife gets up from the stool, and fetches the hand-held Sonicaid[27]. She sits back down, watching again." Observation FMU MW 2.14 W3

6.6.4.2 Confronting interventions

In *'confronting interventions'*, the second descriptor for this sub-theme, midwives accepted that for some women, certain interventions might be necessary. There was a degree of ambivalence in the way interventions were viewed, however. Ambivalence presented itself on one hand as midwives being reluctant to interfere, hoping that the woman (and nature) would make spontaneous progress in enough time such that the need to initiate any action was no longer necessary. On the other hand, midwives could tolerate interventions if they were small scale enough to bring the labour back in line with normality and prevent more significant interventions in the future.

The interventions participant midwives proposed that they might use ranged from carrying out an artificial rupture of fetal membranes (ARM: an 'artificial' act

[27] A Sonicaid is a particular brand of a hand held ultrasound device for auscultating, or listening into the sounds of, the fetal heart.

because rupture of membranes usually occurs spontaneously in the course of a physiological labour), performing an episiotomy in the final stages of labour to increase the vaginal outlet and facilitate birth, and managing the third stage of labour[28] with the use of synthetic oxytocin. It appears that these were considered to be relatively low technology interventions, possibly because the means to carry them out were available to them in the low technology settings that midwifery led units constitute. Use of equipment such as Rebozo scarves[29] or birthing balls, which woman might use in order to optimise fetal positioning, did not appear to be regarded as contentious, instead being considered part of the settings' routine offerings.

In the 'Knowing and understanding normality' subtheme already discussed midwives are represented making use of their knowledge of physiology, and making suggestions to women about ways to enhance progress in labour through being mobile or adopting particular positions, for example. This evidence was taken to demonstrate ***"midwifery led interventions that you can do and work with the woman on [...] that mean […] women still then have […] a normal birth" (FMU MW 2.12).*** The same evidence could also be used to differentiate between midwives' conscious passivity in 'going with the flow' in some situations and

[28] The third stage of labour is conventionally defined as the period directly after the birth of the baby, where the placenta and membranes are expelled from the birth canal, and control of bleeding from the former placental site on the uterine wall takes place.

[29] A Rebozo scarf is a piece of woven material. It has many uses. Among them is assisting a pregnant or labouring woman relax her muscles by using a number of different techniques involving wrapping around the woman's abdomen. The techniques are traditionally used by Mexican midwives.

reconciling themselves to using the low technology strategies captured by 'confronting interventions', in other situations.

"When the woman comes to the room, everything is ready, there's a bean bag, the pool. […] If [she is] suffering, we give advice from the experience we have about what works: massage, music, Rebozo, taking her back to her comfort zone." FMU MW 2.2

"And one of the biggest and best uses is of the pool for water births as well." AMU MW 1.1

Knowing that going through unmedicated and undisturbed labour (labours where pharmaceutical pain relief was not used, and without routine interventions) could be hard for women, midwives had to quell the desire to offer an 'easier' solution. Thus, there were situations of their resisting the urge to 'rescue' women. The experience of such situations could be quite challenging.

" But I think it could be underestimated how challenging it is to give care on a low risk midwifery unit […] because you really have to use your brain all of the time and actually caring for a woman without pain relief can be quite physically and emotionally quite emotion draining because, because she's, she's drawing on almost, well not almost, she's drawing all of her reserves and it's quite challenging to support her and see her going through this process sometimes because you ... you do want to just act like, ok I've got this thing upstairs called an epidural, we can just end this now (laughs softly) AMU MW 1.8

Having sight of a future positive goal, however, made it possible to accept that women may struggle with labour. Thus, a woman's struggle in labour was not necessarily regarded as being negative. In fact, struggle could be seen as part and parcel of the process.

"If she's saying 'oh I want an epidural'; all women say that. Probe a little deeper. I'm not saying to hold back pain relief, absolutely not. But you'll actually find with the right coaching with the right encouragement she'll be fine, and she'll be so happy that she didn't have that intervention." AMU MW 1.8

The researcher observed one midwife's reluctance to 'rescue' a woman from labour pain during a labour on the FMU. In this instance there was hesitancy about

administering an injection of Pethidine to the labouring woman (Pethidine is an opioid commonly used for pain relief). The midwife considered that the woman was close to giving birth. If so, the Pethidine would be ineffective, or might result in the newborn being sedated when born. The midwife encouraged the woman to examine herself vaginally: perhaps if the fetal head was low enough to be felt, and the woman would be sufficiently reassured to forego the Pethidine injection.

"The woman says to the midwives something like 'I know you've got something you don't want to give me'. The midwife responds to her […] saying that the baby could be sleepy when it's born, so that is becomes clear they are talking about Pethidine [...]. [The midwife] suggests to the woman that she feels inside herself to see if she can feel the baby's head" Observation FMU MW 2.7, W3

The midwife coaxes the woman to hold on for a short while longer, without the Pethidine.

"The midwife says to the woman: 'Let's try everything possible to help you to get there. Fifteen minutes? What do you think?' She gives an explanation of how even though at the last vaginal examination the woman was 2cm, that is irrelevant as she could give birth in 1 or 2 hours afterwards." Observation FMU MW 2.7, W3

The midwife tries another tactic. She seeks consent to examine the woman herself, to persuade the woman about her progress.

"The midwife asks the woman again if she will consent to an examination --- the midwife does the vaginal examination and says '9cm [...}', 'you will deliver soon' --- 'you have gone from 2 to 9 cm' " Observation FMU MW 2.7, W3

During the course of data collection for the research, occasions where midwives discussed common childbirth interventions, or were observed carrying them out, were relatively rare. When discussed at interview, it was within a context of reluctance, and concern about the possible consequences. There was a perceived need to have an acceptable reason for the intervention carried out, i.e., acceptable to the midwife giving care. For example, with respect to using an instrument to rupture the fetal membranes during labour, an intervention that is relatively commonplace in obstetric led settings.

"You know exactly the difficulty doing that here. So, number 1, it could be to expedite the birth, number 2, it could be to find out why the FH is going down. […] I think there's a lot of midwives that think 'I'm not gonna do it, not gonna do it …' So again, it's not an easy decision, you have to have all the rationale as to why you're doing that […] Because as soon as you interrupt that whole cycle that's natural. We rarely do it here actually, rarely, I can't even remember the last ARM[30][artificial rupture of membranes] I did." AMU MW 2.15

"So, your management […] everything that you do you have to have a rationale […]. So, there's no need for you to do an ARM or […] another VE before you need to" AMU MW 1.8

Another AMU midwife offered an example of her reluctance to perform another common intervention. She had taken over care from a night shift midwife of a woman who had been in the second 'pushing' stage of labour for 2 hours. The midwife grappled with intervening with an episiotomy, preferring that the woman sustained a spontaneous perineal tear instead.

"So, after an hour with her I came out and was like ' well, she's been pushing for 2 hours, I feel that it's perineum that is holding back, I wanna do an epis ... but I really don't want to do an epis […] but I feel that this is maybe the only thing that will help, because, you know, when you see the head is there but it's covered completely with the perineum ... by skin. The perineum is not letting go at all" AMU MW 1.3

A midwifery colleague was asked their opinion.

"She came in the room with me and she was like 'why don't we give it half an hour and then you can do an epis'. I was like […] twenty-five minutes later, the perineum tore, so she had a second degree tear […] but I didn't need to do an episiotomy. It was good. I was really happy because I didn't want to give that episiotomy." AMU MW 1.3

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[30] An artificial rupture of membranes is a procedure whereby the fetal membranes are broken in order to release amniotic fluid. There are multiple reasons for carrying out the procedure. It is included in routine induction of labour.

Management of the third stage of labour is an area that aptly demonstrated midwives' perspective about routinely interrupting physiological events. As it is during this part of labour that a post-partum haemorrhage (PPH) can occur[31], local and national guidance recommend that an injection of synthetic oxytocin should be administered to all women because it is thought to result in fewer incidences of PPH. Administering synthetic oxytocin is one of the main components of so-called 'active management of the third stage of labour'.

The following extract typifies the attitudes held by some participant midwives about the custom of active management of this stage. The preferred 'physiological' approach of waiting for the placenta and membranes to be delivered by the woman without intervention was considered as the most fitting practice for midwifery led settings. The need for active management was regarded with scepticism. Seeing good results from not actively intervening reinforced confidence in normality.

"Because it's so widely practised here (the physiological approach to managing third stage of labour) that you've almost got your own mini research. I mean I know the evidence is meant to be, and this is what we tell women … it's an increased risk of bleeding blah blah blah […] and I've had more physiological than I've had active management here, I don't know how many deliveries I've had since I've been down here, but lots, where she's not had more than 100, 150 ml. So, I think that in your own head gives you the confidence, and if you have water birth after water birth after water birth and everything goes beautifully, and I think because we are seeing normality all the time, you get a lot more confident with it" AMU MW 1.2

[31] The amount of bleeding considered to indicate post-partum haemorrhage varies, and is often considered to be >500ml.

The issue of how a midwife might assert their non-interventionist stance, even where a woman expresses a desire for the interventionist option, was observed by the researcher during the second FMU birth. In this instance, the woman who had just given birth was asked about her preference for how the placenta was to be delivered ('what she wants to do with the placenta'). Though the woman opted for a managed third stage, including having an oxytocin injection, the midwife attempted to win her over to the fact that all was progressing spontaneously, and such interference was not needed. The midwife did this by explaining, positively, the process that was taking place. The midwife also involved the woman in verifying affirming signs, such as feeling the blood flow in the umbilicus that would be transferred to the baby in totality if no extra actions were taken.

"The midwife asks the woman what she wants to do with the placenta: 'do you want to wait or do you want the injection?', and the woman opts for the injection. The midwife explains that the placenta is separating from the uterus, which is causing a little blood loss, she is encouraged to feel the umbilical cord to feel the blood pulsating through it. So, they are waiting for the placenta. 'Do you have to wait?' the woman asks, and describes the hospital experience of just having the placenta taken out. 'This is not hospital' the midwife says gently. She points out that the cord has stopped pulsating and uses a cord clamp to clamp the umbilical cord and asks the husband if he wants to cut the cord."

"10.14 hrs: the midwife encourages the woman to push, to bear down again, she touches the woman's abdomen and says her uterus is contracting, she is explaining to the woman that there is no clinical indication for the injection; the woman seems more curious about the whole thing than anything else. The midwife suggests the woman move over to the mattress, but as they prepare for that the woman has pushed the placenta out (10.20 hrs)". Observation FMU MW 2.7&2.14 W3

Another FMU midwife described the efforts she might take to convince a woman that there was no indication to act or intervene in her labour, comparing the situation to what the woman might experience in an obstetric led setting.

"As I said it's the woman in labour […] she's asking you many things 'when we do that?', 'when you do the examination?' 'When you check the baby?'
So, just try to say 'ok, maybe in another environment you need to do it because someone is back of your shoulder and wants to know what is it, so you need to act a little more fast'. Instead in this environment you need to be able to wait the right time for taking actions, and be patient, and just talk maybe with the woman. Say: 'look, we need just to wait, because labour obviously is not something what we can really stress and push, but just give it time, no? " FMU MW 2.9

An FMU midwife discussed at interview what steps she might take when childbirth encroached into abnormal territory. She was prepared to take action by carrying out a procedure that may prevent other interventions becoming necessary. This is illustrated by a comment made about inserting a catheter tube to empty a woman's bladder so that (without the bladder in the way) the fetus has more space to descend into the maternal pelvis, making it easier to be born.

"To intervene in a way that's, like, something simple like putting in a catheter to keep her labour […] normal, or to help prevent more intervention" FMU MW 2.12

Connected to the concept of there being interventions that midwives considered acceptable was the notion of midwifery expertise, understanding normality and abnormality: expertise was apparent if midwives appreciated when something about a woman's labour deviated from a path of normality, and knew when to intervene.

Midwives had an understanding that the MLU setting was designed for situations where normal vaginal or physiological birth was anticipated, the setting was 'just for normal birth', the focus and default position of traditional midwifery practice. Furthermore, there was acknowledgement of the importance of creating and contributing to conditions that promoted release of the hormone oxytocin. Oxytocin was therefore associated with physiological childbirth, the environment had to be right and women needed to feel safe to optimise levels of the hormone.

In 'balancing action and no action' was the overwhelming idea that 'no action' was preferable. The associated data pointed to the phenomenon of midwives 'leaving

nature to take its course', where, although the midwife's presence acted as a guardian against adverse events happening, outside of those events, the woman was left to do what she wanted to do in labour without interference. If the woman was progressing in labour, the midwife did not need to direct or make suggestions to the woman. Even if there was something that the midwife wanted to see happen, such as a woman changing to a position that increased the positive effect of gravity on the birth e.g., a change of maternal position, the woman made her own decisions. In this way midwife practice was viewed as needing to be 'passive if it's normal'. Similarly, being 'purposely inactive' implied a deliberate strategy to be present, and aware of what was happening with the birth, and judge when midwifery actions and interventions were needed.

6.6.5 Summary

As with the first of the defining attributes, there is support for relevance for the second of the defining attributes from both cases. Data from each of the sub-themes contributed to exploring how midwifery led care was enacted. The meaning of the defining attribute theme, therefore, was reflected in the empirical data.

For the sub-themes 'knowing and understanding normality' and 'balancing action and no action' midwives considered knowledge from intuition and experience, clinical guidelines, and knowledge of the physiology of birth. Midwives demonstrated their belief in childbirth as a normal life process not requiring routine interventions. They used their belief and knowledge to guide women in childbirth. They were prepared to 'go with the flow of birth', or suggest 'midwifery interventions' such as the use of birthing balls and Rebozo scarves. More 'low technology' procedures would be used if it meant avoiding more significant interventions later on in the labour. However, there was a reluctance, overall, to

interrupt what was happening in a woman's labour; the midwives resisted 'rescuing' women.

Thus, as seen from an example above, some midwives would prefer a woman sustained a perineal tear spontaneously than perform an episiotomy. In this way, a midwife could adopt either of a range of positions during midwifery led care: being 'consciously passive', using either midwifery or low technology interventions.

6.7 Defining Attribute 3: Midwifery led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models

6.7.1 Description of the third defining attribute from literature review

The notable ideas from the literature review (Chapter 2) for the third defining attribute theme are the importance of continuity of care, and the nature and quality of the relationships between midwives and women.

6.7.2 Description of sub-themes

The data related to the third theme came from both study sites, and from interview and observations. It was organised into two sub-themes: relationship and communication. Each sub-theme comprised several descriptors. The descriptors allowed deeper explanation of the facets of the sub-themes. Figure 6.5 illustrates the typology of the third defining attribute theme. This theme looks not only at the existence and quality of the relationship between midwife and woman ('relationship' sub-theme) but also at how specific aspects of relationship are expressed in midwifery practice through verbal and non-verbal exchanges ('communicating' sub-theme').

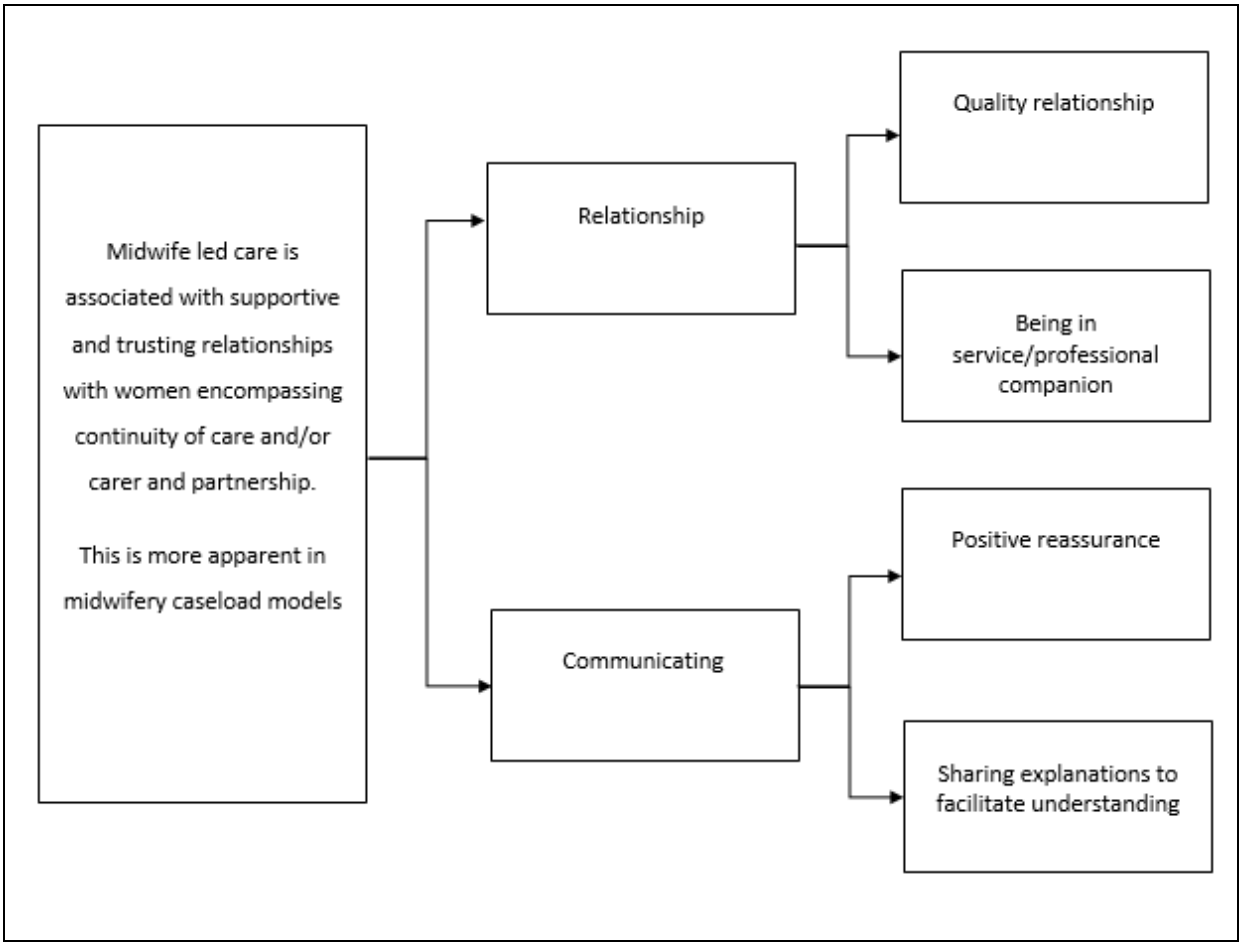

Figure 6-5 Third defining attribute theme and sub-themes
Relationship, communicating and descriptors

6.7.3 Relationships

The existence of the 'relationship' sub-theme and its descriptors: i.e., 'quality relationships' and 'being in service/ professional companion' affirm the importance of relationships to midwives (Figure 6.5). From the midwife participants' perspectives, therefore, it was generally accepted that cultivating a relationship was valuable in pursuit of caring for women in labour. The descriptors consisted of what the participants from both cases acknowledged as being critical. They are expanded upon below.

6.7.3.1 Quality relationships

Midwives had a range of perspectives when explaining the relationships they had with women using their services. They considered that the existence of relationships added value to the exchange between midwife and women. Midwives considered the nature of the relationships that developed. On the one hand it was more than merely a transaction between two parties. There had to be reciprocity; it had to be 'two way'.

"Building more of a relationship and it kind of being more two way […] less transactional" FMU MW 2.12

Furthermore, it was not just about ensuring a safe level of care and treating women respectfully; the connection, or relationship had to be deeper, there had to be a level of closeness between women and midwives.

"[There had to be more to the relationship than] 'ok, [you're] coming here to have a baby we need to keep [you] safe, ok, and we'll be polite to you'. [It's] more of a deeper level. […] actually getting to know people. Like feeling like you're part of their experience. […] you have to get to know them […] for them to trust you, you kind of need to open up a bit to them. […] more […] relational." FMU MW 2.12

"Midwifery led care requires midwives to become close to women to enable women to talk to midwives and explain feelings […] It is not easily explained, but [requires] being able to communicate, have a good understanding; to be with women through their fears [and] happiness" FMU MW 2.2

On the other hand, the midwives put store in being trusted by women, and 'trust' was discussed in various ways. For example, for this AMU midwife, 'trust' was associated with 'belief'. In such a situation the midwife was trusted to do her job of caring for the woman; the woman was trusted or believed capable of succeeding in having a physiological birth. Therefore, a trusting relationship increased the chances of a physiological birth. There was value in the relationship engendering reciprocal trust i.e., both parties trusting one another.

"It's like belief in women […] and belief in what they're gonna do […] and trust, and […] building that rapport so that you can then demonstrate to her, ok, fine

you're birthing, you may never have done this before but I have done my role in this before: trust me […] this is gonna end well." AMU MW 1.8

"And really making her believe in [herself] getting her to feel that belief and […] conveying to her the power of what she's going to do." AMU MW 1.8

A trusting relationship was also seen as being beneficial if, during the labour, there was a need for the midwife to suggest an intervention. An example given by one AMU midwife was where the woman was using the birthing pool and the labour was slowing down. Broaching the subject ***("'what do you think? Think we should try getting out?' " AMU MW 1.2)*** was easier if a quality relationship existed.

"Obviously it's much easier to […] make those kind of midwife decisions because you've got that kind of relationship with the lady. And hopefully you've already […] got an idea of the response, a kind of prediction of […] where that's gonna go." AMU MW 1.2

However, for some of the midwives it was a challenge to establish a relationship with a woman whom they had not met before, or had had limited contact with prior to their being admitted in labour. In such cases relationships had to be developed quickly. It was not just the fact of having a connection with a woman that was crucial, the midwives needed sufficient time to generate trust from the women. Their responses at interviews revealed that they viewed cultivating relationships, or establishing rapport with women, as their responsibility.

"But I think the kind of starting point is getting that rapport really quickly and creating that trust, so that they trust you to respond to them" AMU MW 1.2

"I think that's a really important part […] when you're […] building up a relationship with someone you want to make them feel comfortable with you, you want to start trying to make a relationship very quickly" FMU MW 2.12

An additional challenge to relationship building occurred where women admitted themselves to the midwifery led unit in advanced labour, for example, with a fully dilated cervix and being close to giving birth. In such a situation there was limited

time available. It was still possible, however, for the exercise of 'compassionate care' to be one of the ambitions of the service given.

"[Women] coming in fully [dilated]: the relationship obviously is gonna be limited but you're still giving that compassionate care and that kind of maternal loving and care even if it is in a short space of time and even if it is, you know, quite a frantic period […] and you're still gaining trust" AMU MW 1.9

Midwives reported using different tactics to develop relationships in a timely way. For example, humour to lighten the mood. The aim was for the midwives to present themselves as trustworthy and confident in order to put women at ease.

"On the whole [women using the birth centre] are mostly woman I haven't met before. So, you've got to get in there […] I do it by use of comedy as well, but when it's appropriate […] I try and make people laugh as laughter can […] help move things along […] and quickly make them trust and like you." AMU MW 1.9

As well as humour, another midwife suggested other methods, i.e., displaying a welcoming and inclusive attitude, representing the FMU as a positive environment, or making the women feel valued.

"I think being welcoming is really important and making people feel like […] it's really nice here. […] You want people to think that you're excited to see them, you're excited to be part of their experience and that afterwards you see them, and they're a person to you […]. You get to know people and […] you want them to come and be part of the unit" FMU MW 2.12

In addition, some midwives were prepared to treat woman as though they were close relatives. References were made to treating women like sisters or daughters. In this respect, the emotions that the midwives talked of were about caring, nurturing, and mothering. For this AMU midwife the essence of midwifery led intrapartum care was straightforward:

"It's pretty basic, I just think treating the women as if they were your own daughter or your own sister or a relative" AMU MW 1.10

This sentiment was articulated by another midwife.

"I always […] try to imagine that the person I'm looking after is my sister or my mum, and to treat them the way that I would want my sister or my mum to be treated […] caring, nurturing, listening, all of those things" AMU MW 1.9

Midwives extended this strategy to include the family and friends supporting women in labour. In the three births observed, women chose combinations of husbands, sisters, and mothers as birthing partners. One midwife considered that 'looking after' birthing partners increased women's trust in midwives; others felt committed to making women's families feel that they were important to the birth experience.

During the data collection at the FMU the researcher noted one occasion where a labouring woman was accompanied by her 3 sisters, mother, and husband, as well as having 2 midwives in attendance. Being accommodating was a deliberate tactic to positively encourage family involvement. On another occasion the researchers noticed a midwife hurrying out of the staff office to stop a group of visitors from entering the room of a woman who had recently given birth. Her hurry was not to question the number of people, 5 in total, who had turned up to visit. It was to make sure that the woman was properly dressed before they entered. (From field notes)

"Also, sorting out the partner as well because, you know, whoever is with the woman […] can be ignored, and I think my experience when I was on labour ward is quite a lot of the time they were just ignored. We do a lot down here on the birth centre. They're included in it, so they come as a pair and it's mum, sister, partner, […] everybody is looked after and […] their worries are addressed as well. So, I think by doing that as well you're gaining trust" AMU MW 1.9

Written postnatal care information analysed corroborated the impression that this MLU midwife had of the response to partners.

"I feel like there's a real effort to […] get to know families and for them to feel important. For them to feel […] at home" FMU MW 2.12

"I think that we've spoken more about it, you know, just accommodating their family, just making them to feel safe and making them to feel they're not in hostile environment, as in they're in their own home, that's the whole idea, so their family is able to support them, you know, they feel safer seeing, you know, their family. It kind of bonds them all together really, cos a good experience for them as well. So, I think, that's the major thing really. The family's involved, it's a friendly unit […] it's just quite accommodating" AMU MW 1.5

"Everything that we have available in the rooms, rooms are nice and clean, everything's ... its geared up for a couple, we've got a double bed, you know, it's meant for having a family here. We don't deny small children coming in, their other children, none of that. We try to accommodate wherever we can." AMU MW 1.9 RM 1.9

However, the following comment from the AMU may also explain why it is desirable to have birth partners (or families) in agreement with the midwifery practices on the unit:

"Sometimes it can be really negative […] birthing partners that aren't on board can be really challenging." AMU MW 1.8

The midwife taking time to look after or include the birth partner was particularly noticed when labour care was observed. The midwife was concerned with comfort or with mobilising their help.

"The midwife gets up to help the woman change position, she places the bean bag behind the partner to support his back as he has resumed his position on the bed, supporting the woman." Observation AMU MW 1.6 W1

"The woman instructs her mother to sit behind her (the woman). The midwife brings pillows and places them on the mother's lap so the woman can lean back on her mother, but be cushioned. Her mother is sitting on a bean bag behind her." Observation FMU MW 2.7 W3 (see Figure 6.6 drawing from observation).

Figure 6-6 illustration from field notes
Midwife and family member supporting the labouring woman

Perhaps because relationships with women were felt by the midwife participants to be such a significant and inevitable component of midwifery led care, what happened when the 'deeper' connection with women was not achieved (i.e., a connection that was more than merely ensuring a safe level of care and treating women respectfully) was not touched upon other than by one AMU midwife. Her perception was that it was an inevitable situation that could be resolved by mustering the support of a colleague.

"Sometimes […] nothing works. It definitely happens to all of us cos we're all human, there's just not that connection there sometimes […] Once every, however long, it's happened to me maybe once or twice, where they've walked in, it just hasn't happened, and I don't know why that is […] So as well, acknowledging that […] and trying to work really hard to fix it, but if you can't, getting a colleague in to try and help" AMU MW 1.8

Midwife participants were also concerned with the concept of continuity of care or carer[32]. With 'continuity of carer' women could expect to receive care from just 1 or 2 midwives, increasing the chances of getting to know each other and thus developing a relationship. The midwives who commented on these characteristics expressed different opinions about whether continuity was a necessary component of relationships with women. One FMU midwife had the view that with extended contact throughout pregnancy, midwives could educate women to consider the advantages of the midwifery led service for their labour and birth. Women would benefit if midwives were aware of the entirety of their circumstances.

"Continuity with the women that you see a lot. Trust that you are going to follow that woman up. That you're gonna be that point of contact; that they can come back to you." FMU MW 2.15

"So, if you had the same midwife in the clinic, she'd be slowly able to work on that woman. We have an active birth workshop here […] just seeing the same face we know works, and saying 'Have you thought about that?' Pinpointing them to certain films that they could watch, giving them audits, getting them here and sitting next to someone who's just had a baby." FMU MW 2.15

A continuity model, however, could be a difficult way of working for midwives, even if it had value.

"Getting to know a woman ideally in the pregnancy, that doesn't work too well, continuity, but it does help, and in the labour as well and then postnatally, that's ideal, difficult way of working though". AMU MW 1.6

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[32] In midwifery-led continuity of care models, the midwife is the lead professional for planning, organising and providing care to women throughout the pregnancy, intrapartum and postnatal periods, i.e. the childbirth continuum. This is related to the idea of 'case loading' where childbearing women receive their ante-, intra- and postnatal care from one midwife or her/his practice partner.

Though there was some recognition that 'continuity' had advantages, among the limited expressions of interest in the model, one FMU midwife did not feel hampered by its absence, or the lack of case loading. They were aware, however, of the challenges of looking after women who were strangers to them.

"[The care on the FMU did not exactly include relationship building] as we don't have case loading although that would be good, so the care relies on getting to know women enough" FMU MW 2.2

Conversely, according to the midwives, continuity of carer may not even be a priority for women. Women were also concerned with midwives being kind and respecting their wishes, rather than knowing them beforehand.

"I've never really been totally sold on continuity as in they need to know you all the way through; I know that that's the gold standard. A lot of women just want someone who's kind to them, who respects them and their privacy and their wishes, same with their partner as well." AMU MW 1.10

Neither of the research cases provided a continuity of carer model during the period of research data collection. Because midwives from both cases were integrated into the midwifery community service and held antenatal clinics form other health centres, there were occasions where the midwife was known to the woman before labour.

6.7.3.2 Being in service/professional companion

Several of the qualities of relationship that midwives identified as being significant features of their care represented the descriptor 'being in service/professional companion', because they contributed to the question of how midwives defined the position they occupied in relation to women.

One AMU midwife's emphasised how much she considered herself to be akin to a servant: a 'lady in waiting', where 'ladies in waiting' provide close personal care to aristocratic women, attending to them in a variety of ways, some intimate. In keeping with this status, it was important for a midwife to have certain qualities:

"For me […] I think that the most important thing a midwife should be is humble. And I also think that the most important thing that a midwife should be is zero ego, none, none at all." AMU MW 1.8

The midwife believed that midwifery led settings allowed midwives to provide a level of care which certain women would have experienced in a previous era. Thus, the care midwives provided in the AMU was referred to in the following terms:

"It's almost like […] in old school […] Downton Abbey[33] or something […] you're her lady" AMU MW 1.8

For this midwife, undertaking such a role meant being prepared to be continuously present and available.

"Whether she ends up with a Caesarean or not, you're there for her, you're hers. So, it's making you very very accessible to her". AMU MW 1.8

"You're here to provide a service for her and her family and […] you should be present in that room, all the time, all the time, because if you even seem like you're absent, even the smallest bit, then your heart is not 100% in what she's going through" AMU MW 1.8

This perspective: that relationships between midwives and women necessitated midwives 'being in service', was perhaps more ardent than others found in the data; 'being in service' implied midwives being subordinate to the women they cared for. However, midwives did express their understanding of the meaning of relationships in words that suggested commitment or dedication beyond what was actually necessary to carry out safe routine intrapartum care. Hence, the idea of midwives

[33] Downton Abbey is a British historical period drama television series depicting the lives of an aristocratic family in the early 20th century, set a fictional country estate of Downton Abbey. The period epitomised a time when aristocratic women had lower ranking women at their service to attend to their personal needs.

being ‘professional companions’: skilled in overseeing processes of labour and birth, committed to practices that enhanced the interaction with women. Where it was not achievable, significant emotional reactions could be triggered.

“It’s very very very much […] with woman one to one isn’t it? So […] you're not just there just to kind of do your routine observations. It’s really providing support, properly.” AMU MW 1.2

“You need to give them one to one care, and they absolutely need you there when it's getting towards that: 'I'm feeling pressure', 'I don't know what to do with myself', transitioning […]: ' I want an epidural', all of that's going on. To leave the room, I hate it, I hate it. I think it's really important to have the time. And occasionally it's not possible, you have to come out.” AMU MW 1.9

Some midwives made reference to the ‘partnership’ that existed between themselves and women. Their vision of ‘partnership’ was where midwives were in a position of being able to offer guidance to women about aspects of labour they had more theoretical knowledge about.

“In terms of what's on offer just to say […] ‘this is what you could do’. ‘Why don't you go for a walk?’, ‘Why don't you go and do this, why don't you go and do the stairs?’ Working in partnership, let them see 'this is what we're gonna do, upright positions are good.’
So, it's just working in partnership really.” AMU MW 1.9

“Generally, the midwife led care when they follow the wish of the woman there is decision making with them. So is a plan, what you do for, especially for birth […] and you work […] as a team, so my team is the woman and the partner and the baby.” FMU MW 2.9

6.7.4 Communicating

The ‘communicating’ sub-theme illustrates how relationships were expressed in midwifery practice through verbal and non-verbal communication. The data represents participants’ ideas of what the substance of communicating with women was, and what was observed by the researcher in midwives’ labour care.

There are 2 overriding and interrelated descriptors: ‘positive reassurance’ and ‘sharing explanations to facilitate understanding’ (see figure 6.5).

6.7.4.1 Positive reassurance

Midwives were observed giving continuous positive reassurance to women and their partners. Sometimes this took the form of affirmation that the labour was progressing as expected. The reassurance given was through encouraging words, and non-verbal signs such as a confirmatory smile or nod.

“[The midwife] goes through what she found [from the vaginal examination] ' about 5 centimetres open', 'cervix is really thin now', 'you are getting there'. This information is given to the couple as though everything is how it should be.” Observation AMU MW1.6, W1

“The woman tells the midwife she feels like pushing but that nothing is happening, and reassurance comes from the midwife about how clever the body is, and how the woman has done it before.” Observation FMU MW 2.7/2.14 W3

The observation data contained examples of midwives using positive reframing: offering different, more optimistic perspectives of the situation when talking to the woman about what was happening.

“The midwife […] is looking at the floor, verifies out loud that there is water [amniotic fluid] and says, 'nice and clear', she continues to talk positively about the water, her voice is soft and calm” Observation AMU MW 1.6 W1

“‘What about standing in the shower? Having a hot shower” asks the midwife, and the woman says yes to the idea. She says somewhat mournfully: ‘I don’t feel him going down when I push’; the midwife says: ‘It’s fine; your baby knows what he’s doing, you know what you are doing.’ “ FMU MW 2.7/MW 2.14 W3

“The midwife is on the floor, behind the woman. She says: 'baby's head very low now' […] the woman answers with a question ' can you see it?' She is still leaning over so that the midwife is able to see any advancement of the baby. ‘I can see very stretchy tissue; that means baby is doing the curve.’” Observation FMU MW 2.9 W2

In the latter example, although the baby's head was not yet visible, the midwife represented what she was actually seeing in a positive light.

Affirming words were used to convince women that they were making progress, for example, in explaining that the overwhelming pressure in the birth canal that a woman might be experiencing was related to the impact of the baby's head against her rectum, which could lead to her opening her bowels. In the examples below, the woman's bodily functions, which would not usually reach the threshold of being a fit topic for public discussion, were reconceptualised as comforting signs.

"The woman is more active around the room […]. The midwife rubs her back when contractions come, comments like ' smashing' ' excellent' ' good stuff' […] as the woman first mentions she feels like she needs to 'poo.' " Observation AMU MW 1.6 W1

"[The midwife] sees lots of vaginal mucous [trailing] and says this is a great sign" Observation AMU MW 1.6 W1

6.7.4.2 Sharing explanations to facilitate understanding

As well as affirming words midwives exchanged with women in order to offer reassurance, they were also observed sharing explanations about the signs they noticed women displaying during the labours. The function of these exchanges appeared to be firstly, making it easy for women and birth partners to understand what was happening, thus demystifying some of the processes of labour, and secondly, giving advance notice of what the woman might experience later on in the labour so that she could prepare herself.

"The midwife explains to the woman she may feel more pressure of the baby now that her waters have 'gone'. […] she explains 'you're going to feel water coming all the time now', and says encouraging words to the woman during a contraction." Observation AMU MW 1.6 W1

"The […] midwife says, ' you're going to start stretching'. There is encouragement, 'I can see more of the head.' [She] is off the stool and onto her knees again […] 'You're going to feel the stretching'. […] The midwife says to the woman 'Little

pushes now', […] also ' in a little while I'll tell you not to push' ". Observation AMU MW 1.6 W1

"The woman asks of the midwife whether the placenta will come in one go. The midwife responds that the cord is still pulsating, she has touched the unbiblical cord briefly, and so the placenta may not have come away completely. She explains that when the baby is completely fine and able to do everything by itself, the cord stops pulsating." Observation FMU MW 2.9 W2

The value of midwives sharing their understanding with women and their families of what was happening in the labour was expressed during interview.

"If you're doing vaginal examinations being skilled at that to be able to give feedback in a good way to the woman, a way that's gonna […] help her to feel supported […] and it's […] explaining that to the family." AMU MW 2.12

"First of all, to empower them you have to make sure they understand, I think. They have to fully understand what's happening, any decisions, make sure that they are the person that feels like they're making the decision as well, so that they have the confidence to believe in that decision that they've made." AMU MW 1.1

6.7.5 Summary

The data clearly shows that the third defining attribute is enacted in the midwifery led care observed and discussed by midwives. Data from each of the sub-themes contributed to exploring how midwifery led care was enacted. The meaning of the defining attribute theme, therefore, was reflected in the empirical data.

For the sub-themes 'relationship' and 'communicating' midwives demonstrated how they valued having significant interactions with women and how it benefited the care they gave. A quality relationship engendered trust from both parties. It was of benefit to view women as though they were family members. It was also important to look after birthing partners and be able to mobilise their support. Although some considered continuity of carer and case loading to enhance the relationship, as it was not present at either MLU used in the case study, its absence was not considered to hamper their success. The quality of relationships was also

defined as being at least as significant as that between a woman and a 'professional companion'. Midwives were aware of how they communicated with women within the relationships that they worked to establish. The important features were that they were positive and affirming, and that they shared their knowledge and information about the labour as they witnessed it.

6.8 Defining Attribute 4: Midwifery led care is women centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers

6.8.1 Description of the fourth defining attribute from literature review

The key points from literature review (Chapter 2) relevant for the fourth defining attribute are that midwives need to be in a position to be able to fulfil women's choices. Women need to be able to trust that midwives will honour their choices and a relationship with the midwife helps this. Furthermore, if midwifery led care is focussed on the woman it means that they will be viewed as individuals and their decisions will be taken into account.

6.8.2 Description of sub themes

The sub-themes associated with this defining attribute represent the finer details of midwife-women relationships discussed above. They indicate how midwives enact and enhance relationships with women, revealing a pattern of midwifery strategies and behaviours. The strategies and behaviours represent how midwives exert their beliefs on the care given to women i.e., how their philosophy of care influences practice. The two subthemes, being responsive and making decisions about care were derived from observation and interview data. Each of the sub themes is associated with two descriptors (Figure 6-7).

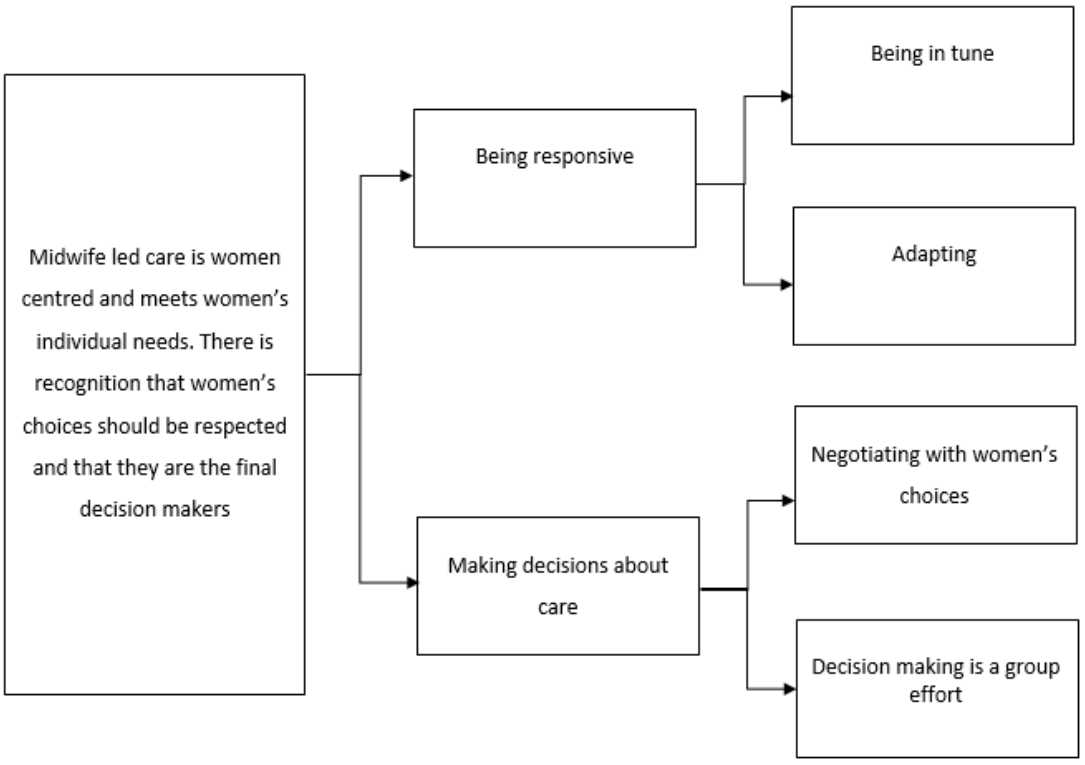

Figure 6-7 Fourth defining attribute and sub themes
Being responsive, making decisions about care

6.8.3 Being responsive

For midwives, being responsive signified how they interacted with women. The actions consisted of responding to women's needs as they arose or anticipating what may be needed to provide comfort or encouragement. The impression given was of midwives striving to be 'in tune' with women, demonstrating the ability to understand what their experiences were, hence, displaying empathy towards the women. The descriptors for this sub-theme: 'being in tune' and 'adapting' are illustrated in the Figure 6.7 and explored in the following passages.

6.8.3.1 Being in tune

'Being in tune' consisted of instances where midwives displayed deep awareness of the woman's condition and empathy with her experience. There was a multitude of factors involved that contributed to the depth of this finding: the midwives are concerned with gauging what women want from the labour care. The midwives aimed to be 'present', in the sense of giving full attention to women. They also engaged with women to the extent of exhibiting reciprocal behaviour by mimicking and joining in with some of the women's actions or movements. Different midwives explained that they gauged what women wanted from them by deciphering their actions and reactions.

"And then if a woman's in her zone with her partner, that's lovely; stay away […]. If she's looking to you all the tiny seconds or shouting out your name […] then be with her. You gauge that level of interaction from her. Cos nine times out of ten the women want you right there, which is lovely. But if they don't, then brilliant." AMU MW 1.8

"Sometimes it can be from using what's in your surroundings. […]it could be something as basic as you […] just kinda invisible in the corner and just there really just to guide when the baby's birthing and that woman's hypnobirthing […] another woman might need you to be a lot more […] active and supportive in the labour. Some women respond much better to having some kind of encouragement […] so you might be using the birthing stool or saying: 'right, you know, shall we get in the pool'. Some women will kind of very much lead their care." AMU MW 1.2

"It's looking after the woman's needs. Her comfort, drinks, going to the toilet, honey, warmth; that somebody's there with her, a voice that she can relate to. That's what you want so that when, during all that time and the birthing time that she's there, you're in tune with her." AMU MW 1.6

"For example, there are women that they don't want you to touch them at all, so, I will respect that and just try to accommodate or try to help her in another way. There are women that they love you to give them massage on the back […] so I will try to see whether the woman that I look after […] at that moment would like this or not […] But I don't like to talk too much in the birth, so I will try to see how she reacts with her non-verbal cues." FMU MW 2.11

For some midwives, being 'in tune' necessitated giving women their full attention, being present when women needed them.

"So, you know, when she's struggling, when things are getting a little bit […]as they do as it's coming towards the end, it's just being there, just being with woman, that's what the word 'midwife' means. It's just being with woman." AMU MW 1.9

"And actually, you just being there, or […] often not being there, just popping in and out if that's what they want, […] that's being with her because that's being with that woman in the way that she wants. It's doing the right thing for her labour." FMU MW 2.12

"Just to, to be present, and to listen what's happened" FMU MW 2.9

Through observing midwifery practice, it was possible for the researcher to recognise certain behaviours of the midwives as demonstrating reciprocity. Thus, part of their support included adopting behaviours that reflected the actions of the women they were caring for. In the first example, the midwife stands close to the woman, massaging her back, and imitates the woman's movement during uterine contractions.

"The midwife is moving with the same rhythm as the woman whilst she rubs the woman's back." Observation AMU MW 1.6 W1

The second example is of a similar situation: both midwife and woman are engrossed in the same action between uterine contractions.

"The midwife is still in the supportive position; she is suggesting quietly for the woman to relax and change position. […] And they are now both standing. The woman holds hands with the midwife, and they are both swaying." Observation FMU MW 2.7 W3

The midwife could also be responsive to the ebb and flow of the labour in the following way:

"The room is silent in between the times that the woman is not contracting. In fact, she closes her eyes and sleeps in between the contractions and the midwife sits silently when she is sleeping. When the woman is woken by the contractions

and responds to them vocally the midwife looks alert to them too." FMU MW 2.7 W3

By mirroring women's actions, midwives were, perhaps, attempting to fulfil a desire to relate to women, and to encourage women to relate to them, an idea expressed at interview by an AMU midwife.

"It's a bit like, you gauge where they're coming from and try to kind of almost be on the same level that they're on, whatever that means, so that you can relate to them, they can relate to you" AMU MW 1.9

Being in tune also meant that midwives took account of the significance of time. Some women needed to be given time to take control of their labour. They needed kindness and compassion.

"Spending time, if you can spend time and get women calm […] Women that are completely losing control, unable to […] cope, and once they're in and you've spent half an hour with them and you've done the kind words and the caring and the compassion and this is before any pain relief or anything has been offered and they get it, so it works, and if you can gain somebody's trust by just talking and calming them, it works." AMU MW 1.9

6.8.3.2 Adapting

Midwives worked around women, with an objective of minimising disturbance. In this way they adapted themselves or the environment to fit in with what they believed women needed, so as to support them. The midwife might have altered her position so the woman did not need to move. In some instances, positions were observed by the researcher that may not have been convenient or comfortable for the midwife. The research field notes refer to the AMU observation of birth where the midwife consistently took up spatially lower positions in relation to the woman. For example, kneeling on the floor whilst auscultating the fetal heart (Field notes. AMU 23rd September 2016).

"The midwife makes a move to listen to the fetal heart and gets onto her knees again to position the transducer on the woman's abdomen; the woman is standing" Observation AMU MW 1.6 W1

"The midwife is on the floor, behind the woman, she says: 'Baby's head very low now.' " Observation FMU MW 2.9 W2

"The midwife […] says: 'Can I listen to your baby?' The woman nods and so now the midwife kneels on the floor, close to the woman and places the transducer of the Sonicaid on the woman's abdomen. She has to twist herself to angle it right" Observation FMU MW 2.9 W2

The efforts taken to adapt self and environment resulted in significant close physical contact between midwives and women. The closeness, in turn, made it possible for the midwives to provide comforting measures such as massage, and support for positions women adopted.

"The midwife and woman talk about what other position might be comfortable for the woman to take up. The midwife describes it as 'all about doing different things'. So, the woman is now on the bed with the midwife massaging her back. She is helped to be comfortable with back rubbing and Entonox; the midwife rubs her back with each contraction." Observation AMU MW 1.6 W1 (see Figure 6-8).

Figure 6-8 Illustration from field notes
Midwife massaging woman's back

"The midwife squats with her feet on the floor in front of the birthing stool [where the woman sits]. She takes both of the woman's hands in hers and she leans back. The woman leans back also [in the opposite direction]. In this way the midwife is supporting the woman." Observation FMU MW 2.7 W3 (illustrated as Figure 6-9).

"The midwife is accompanying the woman as she stands by the pool using the Entonox for contractions; the midwife and woman are close and […] holding hands." Observation FMU MW 2.7 W3

Figure 6-9 Illustration from field notes
Midwife adopting squatting position to support woman

6.8.4 Making decisions about care

This last sub-theme is concerned with how decisions were made about the care MLU midwives gave to women. There are 2 contributing descriptors (see Figure 6.7). MLU midwives recognised the value of accepting women's choices and complying with them, however, they were aware also of the need for negotiating with women to provide the care they felt was appropriate. There were many references to the belief that 'decision making is a group effort', the second descriptor. In looking after labouring women, midwives were consistently observed

involving their midwifery colleagues who happened to be on shift at the same time, in decisions about what to do next at any given point in the woman's labour.

6.8.4.1 Negotiating with women's choices

Midwives operating along a continuum of practice in response to what was happening in a woman's labour is a facet of their care considered earlier in this chapter. For the sub theme 'balancing action and no action' (second defining attribute), midwives demonstrated skills of being 'consciously passive' as well as those needed for effecting more 'low technology' obstetric -like interventions. In between these extremes was the use of 'midwifery interventions'. With respect to decision making, there were multiple indications that midwives were prepared to take into account what women wanted to happen in labour and what their choices were. The rhetoric of shared decision-making and respect for diversity of needs was outlined in the FMU's generic Trust orientation programme for midwives: 'The maternity care provider will respect the diversity of women's needs […] the practitioners involved will encourage decision making as a shared responsibility […] the woman is recognised as the primary decision-maker' (Document 2.08, FMU research site, 2010). MLU midwives were bound to accepting women's choices about a course of action irrespective of the whether it might lead to an adverse event happening.

"We need to move away as midwives from 'allowed' or 'risk' […] What we need to do is say, "ok, here are the chances of what may happen if you have this or if you have this, or if this happens, or if this should happen, because this in your background you are more inclined for this to happen, or something". […] but if she turns round and says, 'I don't care', then we need to go 'alright then, fine, that was your decision, I've given you all that information and if you want to do that then you have our whole undivided support' " AMU MW 1.8

"I think it's no one in power but the woman, […] she's the one that has to get the decision that is more appropriate for her. It's like, you just give the information

and if she wants something that is not on your plans, or, it's up to her as long as she understands the risks and benefits." AMU MW 2.11

"They have to fully understand what's happening, any decisions, make sure that they are the person that feels like they're making the decision as well, so that they have the confidence to believe in that decision that they've made." AMU MW 1.1

Examples in the data also showed how midwives attempted to steer the plan of care in a different direction. In the following excerpts, midwives described occasions where there was ambivalence about whether or not all was well in the labour. The midwives' attitudes were of negotiation in order to bring about a change.

" There's a lot of conversations you have with women: 'we've been going at this labour now for some hours and we've tried this, I think we should start talking about, within the next hour, what we're gonna do' … It's those conversations you had. […] So, the woman is far more engaged with her care." FMU MW 2.15

"I say 'it's better if you change position, let's just go on all fours because it's better for the baby to descend', or […] 'it's gonna be better than the other position because baby's gonna get more oxygen.' I just suggest it, if she doesn't want, I don't force her, but later on, I don't know, fifteen minutes later I might suggest it again. […] But if she doesn't want, we cannot really force her." FMU MW 2.11

"But if I have a feeling something is not really going with the time it should be […] I explain to the woman […] 'to be able for you to go a little more in time as normal labour […] maybe you can try that option', and see what she said. If she said, 'no I don't want to', I can say 'ok you can stay and we will look after what is going on.' " FMU MW 2.9

The principle of midwives negotiating with women about their care was, therefore, one that repeated itself in the data from interviews. In addition, midwives were observed making tentative suggestions to women about what they could do, or requesting permission to carry out care that was related to following clinical guidelines (see the 'knowing and understanding normality' sub theme, second defining attribute, for the discussion about the significance of clinical guidelines in the midwives' practice).

"[The midwife] asks about the woman's position on the bed. […] It is a semi recumbent position, and the midwife introduces the idea of the woman moving position. But [she] likes this position, so the midwife indicates she would like to correct the lack of support the position gives the woman's back, and takes a towel from the cot, rolls it up, and places it in the small of [her] back" Observation AMU MW 1.6 W1

Views that midwives could or should override women's decisions were rarely expressed. Indeed, the incident of a women declining a transfer to an obstetric after having haemorrhaged (see 'advocating for women' sub theme, first defining attribute) illustrates midwives supporting a woman's choice irrespective of the potential repercussion. Nevertheless, some midwives suggested a more problematised aspect of midwifery decision making where conflict with accepting women's choices was possible.

"You know there are women here that refuse to transfer, when they've had a PPH or something and you say 'ok, look, we'll try and get round this. And they've remained because you can't make a woman go. I think that's the really lovely thing, to involve women with <u>their</u> (emphasis in midwife's voice) decision making. And as the only experts here, they really listen, and they really honour that." FMU MW 2.15

"I think, unless her life or baby's life is at risk: if baby's life is at risk or her life is at risk, obviously if she doesn't want we are not going to call the police but we […] might say, 'we have called the ambulance, you need to go because […] you are bleeding, so you cannot stay here we need to go to the hospital. '" FMU MW 2.11

Despite the following comment:

"The woman leads; only in an emergency would a midwife take over." FMU MW 2.2

data illustrating the current and previous themes indicated that the actuality of MLU midwives being positive about women leading care is complicated when there are concerns about safety. Data from the 'advocating for women' sub theme (first defining attribute theme) expressed the idea that the 'birth centre' needed to be a safe place for midwives as well as women and babies. Coupled with this, the impression of midwives supporting women's choices even though they appeared to be emphatically against them ("***'you cannot stay here we need to go to the***

hospital'") signifies the challenge of midwifery care when labour strayed outside the traditional scope of practice.

6.8.4.2 Decision making is a group effort

The decisions made with respect to women's care involved midwives talking to and garnering each other's opinions about the direction of the care. The importance of the group effort was stressed by several midwives as serving varied purposes. It was considered as a mechanism for making care safer: midwives were able to seek advice or opinions from a second midwife, sometimes, but not always, more senior. It appeared to be part of the usual practice for the midwives to be engaged in active collaboration with colleagues.

"It's such a lovely experience to be a second [midwife]. It really is. As much as it is to have one as well. […] If you've got a trickier birth, just having that little hand from a senior colleague on your back, just saying, I'm here, this is fine, this woman is doing fine, is really really lovely. And I think that is why we've got very low transfer rates, because we're very very safe in how we work. There's no rash decisions that are made because of insecurities. It's all very logical, methodical" AMU MW 1.8

"If it's just something that you think you're not hundred percent sure but you're just concerned about this issue, you get your colleague […] seek a second opinion and from there you can then escalate it to either the senior midwife or then to the obstetrician" AMU MW 1.5

The opportunity to discuss options with colleagues was valued even in cases that were not 'tricky' or of concern:

"You work as a team […] that also goes […] if you're with somebody and you're thinking 'umm … I'm not quite sure what to do here, what can I do? This lady's kind of, you know, I've done an ARM, and I've done whatever and she's still kind of that, what else can I do here? What else could be going on here? Em, I need a bit of extra energy'." AMU MW 1.9

Midwives also expressed the importance of being free to discuss women's care with colleagues without being judged, even where they were relatively experienced.

"When you're giving care, when you're making decisions, you can talk them through with your colleagues without feeling judged. You can ask their advice, check that you haven't missed anything. You can get ideas, and share ideas off other people that are gonna improve the care that you're giving: I think that's really important." FMU MW 2.12

"I've been qualified for 9 years now and I'll always come out and be like 'oh I'm not sure. I dunno what do you think? I want do this but I'm not 100% sure' and I will not get 'well you know that'; you will never get that. I will get 'so what's your rationale? " AMU MW 1.3

The relationship between colleagues, and hierarchy, could act as a limiting factor, however. This AMU midwife referred to a difference of opinion she had had with the 'second' midwife. Both midwives had been present at the birth (which had also been observed for the research). The baby had taken a few seconds to breath after birth. The second midwife had clamped and cut the umbilical cord, and called for assistance; the first midwife had felt that tactile stimulation would have been sufficient to stimulate the baby to breathe.

"It depends on the midwife you're on with who comes in. How they approach things and what they do. That's one thing about the birth [the midwife remembered the birth that had been observed]. I mean the baby I think came out, was ok, and I think we could have left the cord, didn't need to clamp and cut. And I wish perhaps I would've said 'no', and just, I remember saying 'let's just stimulate the baby'. But [name of second midwife] is […] a lot more senior; I've been qualified a long time, but she is more senior here." AMU MW 1.6

6.8.5 Summary

For the last of the defining attributes, there is evidence that sub themes contribute to understanding of how midwifery led care is enacted. The empirical data, therefore, supports the relevance of the defining attribute. The subthemes 'being

responsive' and 'making decisions about care' provided both insight and examples of midwives tailoring their care to respond to individual women. They were concerned with gauging what women wanted from them. There were elements of reciprocity evident in their exchanges. Midwives attempted to adapt themselves or the environment to fit in with what women wanted. They negotiated with women in order to come to decisions about care. This was less straightforward when there were concerns about the labour. In such cases, there was evidence that midwives were committed to accepting women's choices, but for some, the midwife could legitimately take over decision making if there were significant risks to the woman or baby. It appeared that for the cases of midwifery led care studied, decision making was a group activity. Midwives saw the value in being able to ask for help in deciding what the appropriate care should be even where there were no pressing concerns about labour.

6.9 Conclusion

The defining attributes and associated themes and sub themes presented in this chapter were found within the observations and interviews in the AMU and FMU. The wider context of the defining attributes was illustrated through document analysis findings. The emerging themes which are novel and not previously defined are presented in Chapter 7.

Chapter 7 Presentation of findings – inductive themes

7.1 Open coding themes

The second of the findings chapters outlines themes and subthemes that inductively emerged from cross case data analysis, a process discussed in Chapter 6. Incorporating inductively derived findings means that the scope of the study can be widened to include data that is closely associated with the overall a priori themes, and contributes to understanding how they are intrinsic to midwifery led intrapartum care.

Two themes resulted from the process (Figure 7.1). Their value is in providing a contextual backdrop to the midwifery practices associates with defining attributes. They provide information about the social and organisational milieu of the study cases. They offer explanations about issues, concepts, and philosophies that drive midwifery practice.

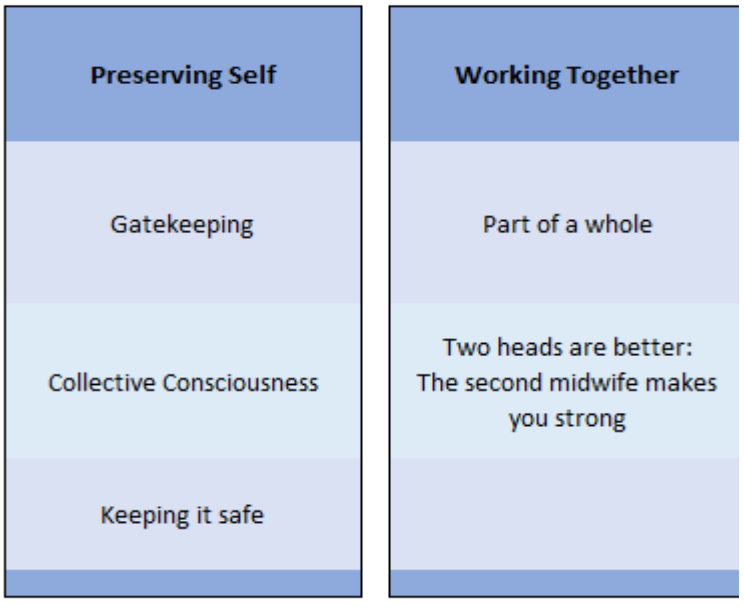

Figure 7-1 Cross case open coding themes and sub themes

The two themes are illustrated in **Error! Reference source not found.** each with associated sub themes.

7.1.1 Preserving self

Midwives from both cases identified characteristics about themselves and the team that were specific to them. There was a sense of 'this is who we are'. They regarded themselves as a collective of professionals with similar understandings of childbirth. Furthermore, there were individual characteristics considered to be valuable for midwifery led care and worthy of protecting. It was important to control, in some way, midwives' entering the territories of the midwifery led units. It was also important to steer midwives into a similar understanding of childbirth, so that they could maintain standards of care and practices considered to be important for the service. The 3 associated sub themes are: gatekeeping, collective consciousness, and keeping it safe.

7.1.1.1 Gatekeeping

The impetus behind this sub theme came from midwives believing that in order to maintain the philosophy and environment of the MLUs, there needed to be some control over who could work there. There was little evidence that MLU midwives had a say in who was recruited to work in their area, either permanently or temporarily, however, when new staff members came to the MLUs, existing midwives made efforts to channel them towards adopting practices that reflected the philosophy of care. The fact that participant midwives did not appear to have influence over staff recruitment did not prevent them having views about who were desirable work colleagues. For one AMU midwife, on occasions where midwives form the 'outside' did staff the MLU, they needed either to be familiar and fit in with the 'dynamic' or be restricted to non labour-care tasks. Restricting labour care to 'insider' midwives was considered an 'untouchable' practice.

"We honestly don't ever have, we (only ever) have an agency [midwife] that comes here regularly. In the 10 months I've been here I've not known it to be staffed from another area. They've called community in who are that kind of ethos, em, so it doesn't seem to change the dynamic. Or if you're calling staff in, they'll be triaging [women] or looking after your post-natals so you're actual, kinda, labour care, it's a bit untouchable really" AMU MW 1.2

By way of an explanation the same midwife offered:

"You can't have people working in a midwifery led unit that don't really believe in the real midwifery skills and have a more obstetric led opinion of things' AMU MW 1.2

For another AMU midwife, there was a specific problem of midwives from other areas not being comfortable looking after women experiencing labour without an epidural or other pharmacological 'stuff'.

"I've seen it from personal experience when you work with […] a midwife that […] doesn't usually work here, usually works on the obstetric unit. […] It's almost like they're not as comfortable with the pain relief options, and they don't quite know how to explain to the women with perhaps 'we should try this, or this'. […] because they're quite used to using epidurals and stuff upstairs." AMU MW 1.1

Another aspect of MLU midwives' views on midwives who were new to the area was the need to be able to scrutinise 'newcomer' midwives' practices to make sure they were in line with how the MLU midwives worked, and in keeping with the self-proclaimed high standards of care.

"People always think we're cliquey. I don't think we're cliquey. Cos cliquey means that we would not, em, embrace anyone else. It's just that when someone comes in, we've got very high standards. So, we're gonna scrutinise you to see do you have the same standards as us" AMU MW 1.3

Though there were no specific details of what 'scrutiny' amounted to, other comments indicated that it was important to be proactive in moulding newcomer midwives so that they fitted in with how things were done on the MLUs. The following extracts from an FMU midwife show a determination to make sure newcomers were up to the responsibility of making autonomous decisions without

a doctor's input, or committed to being genuinely present with a woman, without intrusions such as inappropriate conversations.

"You're guiding them. You're opening up their minds a little bit. The reliance in hospital with doctors' decision making, buttons to press, people to come in --- We never know here when we're gonna get a flat baby […] we've got to […] really get those midwives to feel really --- confident, in their skills that, ok you've pushed this labour long enough, you might have a flat baby.' […] it's an innate ... 'are you ok with that? Give Pethidine? Are you sure? She's a multip, I know she's 2 cm --- ' […] for them to make those decisions, to really --- go back to the woman and say, 'you know actually, thinking about it lets try something else rather than pethidine because --- you know it's a risky situation right now with your baby.' And for them to do it, not expect the senior person to do that. You want really strong midwives that are making those decisions with women. FMU MW 2.15

"So, when they first come here, they ask, ask, ask all the time. So, you kind of have to push them in the room because often they're not in the room. You have to push them there and say, 'you're meant to stay there, you can't keep sitting out here'. 'You've gotta get an insight into that woman, you've got to really observe.' " FMU MW 2.15

"A lot of silence, a lot of observing, so you teach them to de-school and stop talking through people's contractions and talking to the woman " FMU MW 2.15

7.1.1.2 Collective consciousness

The MLU midwives showed that they had a collective consciousness. It consisted of shared beliefs about and attitudes towards childbirth, and an understanding of who they were as a community of midwives working in their discrete settings. Their collective consciousness was indicated by several different factors. For example, there was commonly held belief in the importance of physical environment, and commitment to organising it to suit women and normal birth.

"So, the environment first of all I think promotes normality because it's not set up just a room with a bed, we use the bean bags, we keep them mobilising, and keep them active during their labour as well." AMU MW 1.1

"Yes, we try to keep things normal: the environment, the hormones, endorphins, reduce adrenaline. Actions taken to help women to keep calm, lights are dimmed,

music can be played, voices are kept low. All this helps women to relax and progress. We see amazing cases. […]
It works for the women. […] taking account of voices, the surrounding noise, smell, pictures on the walls, support from midwives, not being patronised, not pressurised." FMU MW 2.2
" I think it's really helpful […] when you've talked to a woman and anyone that she's got with her, you know what kind of, makes her comfortable, what she wanted, so you're kind of making that environment for her but it's very much led by what she'd like. And then you see how she responds to it and you either change it back or you change it to something different, or you know that that's helped." FMU MW 2.12

"I'd have the lights over the bed, I'd put the bean bag on the bed, I'd put music on the television, if it was daytime may not close the curtains, but if it was a night baby, the fluorescent lights that shine through. So just to create the nesting I suppose, a calmness. " AMU MW 1.6

In addition, MLU midwives perceived meaningful differences between the MLUs and obstetric led units (OU) to which both sites were linked. The differences strengthened the idea of existing as separate entities from the OUs, resulting in different possibilities for how they delivered care. They considered that the care they were able to offer contrasted fundamentally with that available at the OUs. They seemed to have a greater sense of their own identity because of the existence of the OU or 'hospital' with which they could compare themselves. The consequences of the differences were regarded sympathetically by some. That is, working conditions and physical environment of the OUs could make it difficult to apply the same standard of care to women, when compared to the MLUs. There were references to the relative advantages of both the environments and mindsets present in the MLUs.

"For me to get a woman marching round the labour ward in bright fluorescent lights with crash trolleys and beds in the corridors and doctors going in and out of rooms and emergency bells going off --- that's a very very very different environment to me having the woman marching out in a nice dark corridor, sitting on a birthing ball with the television in the background and nice and calm with the Phalaenopsis orchid" AMU MW 1.2

"I think because […] the workload […]. In the hospital in the labour ward there is much pressure because there is always women coming in and there is always the

pressure of needing beds and needing to go quick. For example, the physiological third stage of labour: in here we can wait up to an hour, it's fine, and it's not a rush as long as the lady's not bleeding. But in the hospital if you do that, you can do it, but you feel the pressure that they are asking you: 'have you finished, have you finished?' (Laughs). And it's like, you really need, not need, but it's like you feel like you need to give the injection to finish quick quick quick." FMU MW 2.11

"There's a high rate of water birth, physiological third stage in here; you tend to find on labour ward there's a kind of fear of those things." AMU MW 1.2

One AMU midwife suggested what an effect might be on midwifery practice of operating within different settings (MLU or OU). The midwife described the general practice of deliberately misrepresenting findings of a vaginal examination, for it to appear that a woman was not in established labour. The purpose was to 'buy time' because once in established labour, women would be subjected to interventions if they were not making progress according to timeframes recommended by clinical guidelines[34]. The implication was that such timeframes are unwarranted in normal labour.

"Everything is driven by numbers, so once you get to this magical 4[35], which is made up --- it's ambiguous --- then the partogram[36] starts. So, what we would probably do is to say that she was 3, just to buy her a bit more time. So, we can get away with that more in a midwifery led unit because […] we're all of the same mindset. But if you try to do that in a labour ward setting where not everybody is

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[34] For example, national guidelines suggest that delay in labour has occurred if the rate of cervical dilatation is less than 1 cm every 2 hours in established labour.

[35] The 'magical 4' refers to the cervix being 4 cm dilated, at which point the woman is, by convention, considered to be in established labour.

[36] The Partogram is continuous pictorial record of events and progress in established labour over time, completed by the midwife giving labour care. Both maternal and fetal observations are documented (e.g. vital signs, cervical dilatation, and fetal heart rate). It is used to assess whether intervention in labour is needed.

of that mindset, then you would be, you know, tall poppy syndrome, raising your head, ready to get shot down […] To do that anywhere else [other than an MLU] would be, em, well I wouldn't say foolish, but you'd be fighting a losing battle […] It's the cultural norm isn't it? […] So, the cultural norm here is very different to the cultural norm on labour ward." AMU MW 1.10

Although acknowledging it as a practice of 'doing good by stealth', the midwife lamented the fact that the midwives did not collectively own up to what the true clinical picture was.

"But there is a lot of doing good by stealth which ultimately I don't agree with purely because, you know, collectively if we could all come together and just all raise our head above the parapet and just say 'no, […] she's actually 4 cm. No, I'm not gonna start the partogram yet because there still needs to be quite a lot of rotation, descent' " AMU MW 1.10

The contrasts in mindset between the MLU and OU (the OU is also referred to as 'the hospital' by FMU midwives) was also alluded to in the next extract. For this midwife, one consequence was that at the hospital there was a tendency to focus on abnormality or deviations from physiological labour.

"There is I think a kind of mindset in the hospital. The mindset is when you work a lot in that environment, is 'I'm looking for the events what is not physiological', than look for promote the physiology. So, it's a different set of mind.
And I don't know if it's related to because you are trained like that, because you have the fear of something happen, or because that is what you have. Er, you work always in that environment, so obviously you are not able distinguish any more (laughs) the normality or not, because I see a lot of woman what is normal and they treat them as potentially danger […]; that is the mindset." FMU MW 2.9

Yet further evidence for the existence of a collective consciousness was provided by research participants' responses to the vignette of the Model Case of midwifery led intrapartum care (Chapter 2) presented to them during interviews.

The Model Case has been discussed in Chapter 2 and results from the initial concept analysis of midwifery led care, the precursor to the research project. The Model Case represents what literature suggests should be present in cases of midwifery led care. The MLU midwives were invited to express what the vignette meant to them. One particular midwife was clear that the Model Case depicted an encounter

with labour and birth that was "***not idealised"*** and "***not unattainable***" (FMU MW 2.2). Midwives unanimously recognised the Model Case as being what MLUs epitomised. They identified, collectively, with the ethos of women-centred care and non-intervention that the vignette portrayed.

"I mean it sounds very familiar, it sounds kind of --- you know, ok this is happening, ok, give her a bit of peace and quiet. See where things go." AMU MW 1.2

"I mean it sounds very standard for the birth centre; the dim lighting, the nice and relaxed environment, the good encouragement as well." AMU MW 1.1

"Well, it looks like what we do every day (laughs) […] it's very common for me. […]That would be, er, normal practice […] It's perfect. You know, you let her do what she wants. Having a nap is really good you know, going in the water when it's needed" AMU MW 1.3

"Oh my god, it's so birth centre. […] Typical freestanding model of care" FMU MW 2.15

"It's exactly what we do here. We don't limit the visitors. If the woman decides to have someone, how many supporters, we allow her, it's happening to her, that's what she wants to do. We try to keep calm, as calm as possible. We allow time. We give her a chance to do whatever she wants to do, if she wants to rest, she can rest. [..] I think that all the things that you describe there [in the Model Case] is what we do here." FMU MW 2.3

7.1.1.3 Keeping it safe

The final sub-theme for 'Preserving Self' showed the concern midwives had about safety. Their perception was that MLUs were regarded by OU staff as not being safe places for women to give birth. Thus, they believed that MLU practices were eyed with suspicion. Conversely, MLU midwives were critical of their OU midwifery colleagues for being fearful of normal physiological processes. There was a sense that MLU midwives considered themselves to be operating at a boundary or borderline of care.

"I think because when we opened as well there was a lot of negativity coming from other areas […] so you kind of have to stand a little bit stronger. You have to be bloody good at your skills, and your neonatal resus and all the bits and pieces that you may need, because even though you're co-located you kind of feel a bit separate because you've been made to feel a bit separate. And again, I think that that's a power thing, because the balance of power shifted from the doctors to the midwives and to the women" AMU MW 1.10

"Here you've got --- have women that rely on their intuition that they're gonna […] be looked after --- and they're gonna have a safe normal birth. [..] Some women will change from wanting a caesarean. If you work on them really carefully, you draw out that intuition, you give them the right information, they'll come here. And they're not doing that at the hospital. We're viewed as unsafe, and we're viewed as strange midwives that want to work like this, why would you want to work like this? " FMU MW 2.15

The MLU was, therefore, akin to a border town, somewhat feared by the host OU, somewhat regarded as an oddity. As expressed in conversation with the researcher and an FMU midwife, one of the most uncomfortable aspects of midwifery led care was the feeling that when you were in it, you were on one side of the border, an outpost, and it was the side with the swamp (Field note. FMU 31st July 2017).

MLU midwives believed that the MLU was known only for transferring women who were experiencing complications. Thus, they were continually offloading their problems. That impression could make more vulnerable MLU midwives intervene sooner than needed just to avoid being criticised by OU staff.

"I think it's sometimes the impression that labour ward gets from us […] because we only transfer problems, I think they only … have the impression […] that we create problems, which is a false impression. So sometimes we get attitude when we transfer to labour ward. And, like, I don't care, but maybe some more vulnerable midwives […] who are not sure about themselves will maybe transfer when it's not needed because you are scared that, you know, if something bad happens, they'd be really told off, and 'oh what's labour ward gonna think about me', and 'I'm gonna get some problem when I get to labour ward'. You know: 'why have you transferred her now, you should have transferred her an hour ago.'" AMU MW 1.3

Compared with adverse events[37] happening on the OU, when similar events took place on the MLU, there was a tendency for the MLU midwives to be more readily blamed than their OU colleagues.

"Birth centre is very easily blamed, as labour ward is not, because they can hide behind doctors. We can't so we're exposed." FMU MW 2.9

"And when something goes wrong of course it's massive at the (names the FMU), but it goes on every day on the labour ward." FMU MW 2.15

That safety was an incontrovertible feature of midwifery led care settings for low risk women, however, was expressed by one AMU midwife.

"I think safety as always, cos we know that the best place for somebody to be that's low risk is a birth in the birth centre, so to me that's promoting safety as well." AMU MW 1.1

Furthermore, midwives felt that they were suitably preoccupied with safety and acting when something was not 'quite right'.

"We work within the safe parameters and obviously if something is not right, we'd be saying to one another, thinking, we need to do something now. […] When something isn't quite right, you know, we communicate; communication is paramount in this area. Communicating to our colleagues that: "I'm not too comfortable with this." AMU MW 1.5

"We know when something's not quite right, and we'll go and talk to other people. So, for me, midwifery led care is doing all of those things, and not taking any risks." AMU MW 1.9

[37] An adverse event is an unanticipated event that occurs during an episode of care giving by a health professional. The result may be injury or death.

In the context of safety, several midwives commented on the practice of making MLU care available only to those women presenting with minimal risk factors and complications.

" It's, em, midwifery led care in midwifery led units caring for a particular group of women with no medical complications, they've actually been risk assessed, just to exclude any complications, you know, as much as possible, that they would not be needing obstetric review or doctor's input. So these are special kind of women that's been selected during their pregnancy, risk assessed, we start risk assessing them from about 36 weeks, and as long as they've had normal pregnancy, all their bloods are fine, there's no cause for worry, then by 37 weeks if they go into labour, they come right down to us" AMU MW 1.5

"Midwifery led care is, em, women who have been risk assessed as being low risk" AMU MW 1.9

"The woman should have to be the low risk woman who has got no complications, making sure clinically she's fine." FMU MW 2.8

"For this midwife, midwifery led care involved looking after and supporting women who were low risk, and did not need medical intervention." FMU MW 2.2

In reality, midwives were aware that despite not wanting ***"to take women that […] obviously, they are at risk and just endanger their lives" (AMU MW 1.5)***, they might also be confronted with the somewhat contradictory situation of having to accommodate women's choices of where to give birth even if they were not low risk and complication-free.

"You can't say to her "You don't fall into our category, we're not going to be able to look after you", but as long as she's aware of the risk and it's all documented, then you have to give her the care that she needs. At every stage in time, you have to keep reporting to your senior colleagues so that everybody is aware of what is happening and the woman is continually being updated so that she can know the risks that she is taking, and that's all we can do really." AMU MW 1.5

Not only could such situations affect safety in the MLUs, they also complicated midwives' visions of themselves as facilitating women's choices, discussed with the sub theme 'Advocating for Women' above (Chapter 6). MLU midwives were, therefore, committed to maintaining the MLUs as safe places. They were keen to

demonstrate competence in managing obstetric emergencies, for example. One FMU midwife conveyed the need for skills in detecting and responding to deviations from normality to be beyond reproach.

"First you need to learn to SBAR[38] really quickly, to take all the evidence and knowledge that you have and say, 'this baby is stuck'. 'This baby … we have a protracted labour. This baby is not moving, its asynclitic […] we need to move […].This is the conversation we have with a midwife: 'this woman's dehydrated, she needs --- 'It's those sorts of things. […] SBAR that woman and don't tell me 'oh I think she's quite dry'. We've stopped talking like that. You have to be really definitive. You are that person looking after that woman. Your skills and drills[39] have to be shit hot." FMU MW 2.15

For another AMU midwife, it was important that the MLU was able to demonstrate skilful emergency care to OU colleagues, to prove themselves as competent and safe. Her account of an experience of dealing with a haemorrhage is given below.

"We had that emergency […]. We crash called it, and the doctor feedback were 'I've never been in an emergency where everyone was so calm' (laughs). [..] It was like:
'I think she's bleeding a bit',
'Ok'
'I'm gonna get the trolley' Got the trolley.
And she's like: 'can you get ergot?'

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[38] SBAR is structured communication tool for giving information to other individuals. It was developed by the US military and has been adopted in many other settings, including healthcare. Hence the information is given about patients and service users. SBAR consists of standardised prompt questions in four sections: Situation, Background, Assessment, and Recommendation. Using SBAR encourages staff to communicate the right content and level of detail.

[39] 'Skills and Drills' consists of training in managing obstetric emergencies based on working through simulations.

'Ok'
'Ergot'
'Still bleeding'
'I'll do the crash call'
'Ok'
Crash called it and then 'and can you cannulate?'
And by the time doctors arrived she was cannulated, 40 units were going, she had the indwelling catheter, all within 5 minutes." AMU MW 1.3

There was an added layer of complexity for the FMU midwives. During the period of data collection, the NHS Trust opened a new collocated midwifery led unit on the same site as the obstetric led unit (i.e., a new AMU). FMU midwives were convinced that the new AMU was being promoted to women as a safer and more desirable option to the FMU. The FMU midwives, therefore, felt bypassed by other community midwifery teams, likely to be responsible for influencing women's decisions about place of birth. There were many staff room conversations witnessed during the research that related to the new AMU. Its opening seemed to have had immediate impact i.e., a reduction of women using the FMU to give birth. Audit data showed that a reduction of over 220 women booking for intrapartum care at the FMU and 100 fewer births, comparing figures from 2016 and 2017 ((Document 2.12, FMU research site, 2018). The following is an entry in the research fieldnotes which describes the researcher's impressions, as outlined by the midwives:

"I am thinking about the effect of the newly established AMU on this case, the FMU, and how it has led to a reduction in numbers of women wanting to use the FMU. What does that mean for how women view the relative merits of the place and how does it reflect the wider community of midwives' support for the FMU. Do they encourage women to use this space […] It means that despite evidence to the contrary women are not using the most appropriate place for them?"

Thus, the FMU midwives' already marginalised position was further threatened by the presence of an AMU, which, as a facility, was considered more agreeable by the host OU, and by other community midwifery teams.

"Being seen as separate from the rest of the hospital when we should be using (terminology such as) 'sister sites', we should be using language that encourages

us as being related, and we don't use that. The AMU should really use us as their sister site. We should have been there for their grand opening. You know it should be like 'we're a team, we're a family'. But it's not done, that would really help us. […] The AMU is viewed as safe. And we're viewed as unsafe. That is basic." FMU MW 2.15

In the next quote, the midwife expressed scepticism about the AMU being able to deliver true midwifery led care when situated so close to an OU, inhabiting the same building, and divided only by a floor.

"I think is not possible because when you are next to an hospital you are already in an environment what is not (midwifery) led care. So, the birth centre or the (midwifery) led care should be outside of the hospital. The hospital is a place for people who is ill or need medical care. So obviously is not (midwifery) led care. Is not really a floor can divide that. Is just the same building and the environment. […] In fact, all the time they open a birth centre, […] after, it becomes a second of the labour ward where is intervention. […] The midwife, actually, they are working in different environment but the mentality, the preparation, the attitude is […] the same." FMU MW 2.9

7.1.2 Working together

The last of the inductively derived themes consisted of what was observed of or conveyed by MLU midwives about working relationships in the MLUs. The associated data explained what MLU midwives thought of as being important for relationships to be effective, and the impact of such relationships on how they coped working in complex circumstances.

The nature of both research sites was such that intrapartum care was the responsibility, on any one shift, of a small team of two midwives (a first and a second midwife available, ideally, for each labouring woman), a maternity support

worker[40] and a ward clerk/receptionist. However, as explained in the individual Case Profiles in Chapter 6, midwives working at MLUs had duties other than providing intrapartum care. FMU midwives integrated intrapartum care shifts into their working lives, alongside running postnatal clinics and 'active birth' antenatal sessions. Some of the AMU midwives also worked in the 'community'. In looking at the two associated sub themes of 'working together', a distinction can be drawn between how midwives felt about being part of the wider team occupied at the MLUs and how they viewed the importance of the relationship with the one other MLU midwife they worked alongside on any given shift. The former represents the sub theme 'part of a whole; the latter refers to 'two heads are better: the second midwife makes you strong'.

7.1.2.1 Part of a whole

Midwives referred to different attributes of their teams. They discussed how important working together well and being in a supportive team was to the success of the MLUs.

"The teamwork, I mean, the teamwork, that's the key word; it's the teamwork." AMU MW 1.5

"That's a good thing: teamwork. We are good, we are teamwork; we do work very much as a team. All the midwives and MSWs [maternity support workers] who work here, we're good together. And we also I think, we learn off each other. We never stop learning." AMU MW 1.6

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[40] Maternity Support workers, also known as Maternity Care Assistants, are unregistered healthcare employees. They are part of the maternity team providing direct care to women and families in maternity settings. They work under the direction and supervision of a registered midwife.

"It's the being with women and working with women and, you know, it's the love of doing that and creating a team, a really close working team." FMU MW 2.15

For some there was a sense of being part of a family, complete with the 'ups and downs' of normal family relationships.

"It's very much such a sort of family kind of feeling. I think that really emanates through the care that you give. That everyone seems really supportive of each other. […] And I think that kind of filters back to the care that you deliver." AMU MW 1.2

"Because we --- we know each other very well, and we care about each other […]. Like we all know what's the boyfriend's name, what's the husband's names, what's happening in our lives at the moment. Em --- what's sad in our lives or what's happy in our lives, we all know that about each other.
[…] that's really important, it's like a family, so, because it's like a family sometimes we shout at each other (laughs). And we're not happy with each other but we always end up being best friends again. AMU MW 1.3

During the data collection period at the FMU it became clear that there was an unspoken rule of any staff present would have lunch together at the same time of the day. They would sit in the public space of the waiting area, sometimes sharing with women, families, or visitors. Chatting, laughing, and catching up with each other's lives was taking place.

Having effective midwifery managers or leaders was also considered to be important for the good of the team. Midwives recognised the value of leaders who role modelled desirable behaviours (displaying openness, encouraging discussions about women's cases), who were the glue that held the unit together, who demonstrably cared about the units, and who challenged and held midwives to account for their decisions.

"And then strong midwife leadership. Like, I think what made it work in the beginning is really [names one of the mw managers instrumental in setting up the AMU] because [...] she's the glue […] she's what makes it together. [...] And I think it's like role model, and we had a perfect role model. And that's how it started. And because we had her, we all wanted to be her." AMU MW 1.3

"Effective management. Management that thinks the same way that you think. (Name of manager) is beyond --- above and beyond as a manager. She supports our decisions, she always challenges us: 'what's your rationale for that?', so that you start thinking when I'm doing this: 'what's my rationale for that?' Don't do anything unless you have a really good reason for something cos then it's not midwifery led care, she [the woman] might as well be up on labour ward." AMU MW 1.8

"I think good management. I think actually having a manager that really cares about the place makes a huge difference." AMU MW 1.2

"I think […] it's partly that from the day we opened, and we had [gives names of several senior midwives/ managers] […] who actually got everything together and set up the birth centre […]. Right from the very very first day we talked, and we discussed things, and it's always been done. And I think that's because [names one of the senior midwives again] would be here quite a lot of the time, she would be coming and say 'oh, I've got this lady, this is happening, what you think I should do?' So, having that kind of openness, that's just the way we've kind of been nurtured along as a birth centre. That's the way we are." AMU MW 1.9

Another aspect of being 'part of a whole' was the acceptability of midwives seeking opinions about the care they were giving and suggestions about other practices they could try. Asking for help in this way was not regarded as evidence of failure. Not only was asking for help thought of as routine, it was also suggested as a desirable trait in midwives: being humble enough to admit not knowing what else could be done, and being generous in sharing suggestions.

"We're quite a close-knit team and we tend to work with the same people, rotate round, so you get to know how everybody works and the way they're sort of thinking. […] You work as a team. And that […] that also goes for, em, if you're with somebody and you're thinking 'um --- I'm not quite sure what to do here, what can I do? This lady's kind of, you know, I've done an ARM [artificial rupture of membranes], and I've done whatever and she's still kind of that, what else can I do here? What else could be going on here?" AMU MW 1.9

"So, if you're in your room and, say like ---you know --- the baby's asynclitic, deflexed, the whole lot, yeah? […] all of our midwives will come out and say to anyone: 'Any ideas? This is what I've tried, da di da di da … anything else that I can try?' And you'll get a couple of suggestions. Whereas I noticed when I was on labour ward no one ever did that. They'd go straight to the doctor and say: 'OK, my lady … blah, blah, blah …' Whereas here […] it's not seen as a […] not like a failure, a lack of knowing, to ask for help […] It's just about being humble and

acknowledging when you don't know something, and you've gone through all your repertoire of what you would normally do in this situation and it hasn't worked so far, and asking for help. And being, em, sharing, being generous to share what you know." AMU MW 1.10

"The reflections we have after a birth, the discussions and sharing with everyone, everyone voicing their opinion: that's what it is like being part of the team, always talking about the care to understand better. It's not about how many centimetres; we go into everything." FMU MW 2.2

7.1.2.2 Two heads are better the second midwife makes you strong

It is important to separate out the entity of 'two heads' working together i.e., being or having a second midwife, from other aspects of teamwork because it reflects clearly expressed importance attached to it by the research participants. The experience of having another midwife present in the birthing room was manifestly worthy of comment. There were many references from both research sites to the significance of the second midwife, either being one, or having the support of one. There were also observations made of the dynamic between the primary and second midwife.

Whilst collecting data at the research cases, the researcher sensed that midwives regarded giving care to women as a collective responsibility. Trying to understand what was going on with respect to this subject area prompted the researcher to make the following field note:

"I always wondered how the second midwife fitted in at the Birth Centre as is seemed like more than another colleague to share ideas about care with and to consult over a particular issue. I noticed the second midwife going into a room where they were not leading care, unsolicited, not asked for, not in response to a request from the first midwife. On the other side, in the midwives' office, I had a sense that midwives regarded women as a collective responsibility, there was acceptance of all being involved." (Field note. AMU 26th September 2016)

Second midwives were valuable because they shared the workload. They could carry out specific functions such as taking over the auscultating of the fetal heart (listening into the baby) or keeping the room clean, or taking over record keeping

at a time in the labour when the primary midwife needed to concentrate on the woman.

"When you're going in to be a second, you're not just going in there to just stand there, you're going in there to help, you're going in there to clean, but you're going in there to learn." AMU MW 1.8

"One thing is, cos you're gloved up, and then you've got the Sonicaid listening in, and you've got the hands --- might be grubby, it's a real conundrum isn't it sometimes? […] and that's what is asked of me actually, if I go in as a second midwife, to do that listening in bit." AMU MW 1.6

"Sometimes it can be a little bit too much and documentation is one of the key things as well. So, when the midwife is with the other lady --- I mean, sometimes it's impossible for her to keep adequate record of it because the woman physically needs her to be there. [...] So, it's a very good practice you can have that luxury of second midwife coming in." AMU MW 1.5

The second midwife performing a useful function was also directly observed by the researcher.

"The second midwife enters the room […]. Both midwives busy themselves getting the room ready. (Later on) the midwives are both in position to visualise the birth […]. The primary midwife has gloves on, (the second midwife) is very close. (She) listens to the FH with Doppler[41]" AMU Observation

"Another midwife, the second midwife, is in the room now. The primary midwife instructs her that the baby is coming, asks her to get the notes and to write in them (make a record of the care given), so the second midwife leaves the room again to fetch the paperwork." FMU Observation

For an AMU midwife having or being a 'second' was viewed as important for learning how her colleagues practiced, comparing it to her own ways of working or

[41] The handheld ultrasound device used to auscultate the fetal heart, also referred to as a Sonicaid

communicating with women, or a chance to have her own routines reflected back at her.

"Actually, the amount I've learnt off my colleagues […] you hear somebody say that and you think: 'I've said that and that sounds really bad' or: 'I can't believe that that's the way it sounds' or also: 'What a lovely way that she's just worded that!'. Or actually 'This midwife's not doing anything at all, and she doesn't need to, this is lovely'. Or 'Ok, this midwife is really really involved'." AMU MW 1.8

The second midwife could also be considered as fulfilling a 'moderating' role, an arbiter not so much between midwives and women, but in helping a particular midwife make decisions about care.

"It's like a moderator, you know, when you start to freak out on your own, cos you're like: ' am I doing the right thing'?' You've got the moderator that is actually going to moderate and not make it worse." Amu MW 1.3

In addition, being able to call upon the second midwife's skills was likened to passing on the baton, sharing the responsibility. This was particularly appreciated at times of midwives being overwhelmed, or lacking in energy.

"Because (of) my energy levels, I needed (name of second midwife) to come in and pick things up again for that woman, that's what I needed, I needed to pass that baton on." AMU MW 1.8

"I had an experience with one of my colleagues last week, and it was a primip, quite hard going, […] so I just had to go in there from time to time to support her. Cos she was, she was like almost giving up, 'She's not going to deliver". I thought: "Ok, know what? Go and have a drink and I'll take over from you". Then you can come back together, and we sort of did it together" AMU MW 1.5

"We are all very good […] at saying: 'ok, right I've been in that room for this amount of hours'. Sometimes you can't see the wood for the trees anymore. '[…] I need a different energy in my room, can you come in?'." AMU MW 1.10

The dynamic between the two midwives was voiced almost reverently in the following account of a labour. The baby's head was not advancing ('crowning'). The

primary midwife had been present from the beginning. The second midwife came to assist and both midwives worked together to provide the care.

"So, my energy levels had been completely sucked that whole entire day. This woman was amazing, but it was exhausting. So (gives the midwife's name) has come in; […] and […] she'd look at me, give me this look, we'd try McRoberts[42], we'd go back to changing positions. […] And she'd look at me, she'd look at something in the room and I would go and get it, and we --- we actually never spoke but I'd never noticed it. Because the following morning […] I'd gone into the woman, and the woman had said 'you're like sisters', and I said, 'what do you mean'. She said, 'you two must love each other'. […] She was like: 'you were communicating with your brain power yesterday, it was amazing'." AMU MW 1.8

Finally, for this AMU midwife, the presence of a second meant increased self-assurance and security.

"I think the second midwife is what makes you strong. Em, it's like your foundation (laughs). I don't know if it's --- how you can use it but em, I've got my second I'm not scared. And because I'm not scared, I'm not scaring the woman. And now … and I feel so safe that I can allow myself to --- to be that midwife who will deliver in a midwifery led unit, because anything that can happen, I can deal with it because I've got my second." AMU MW 1.3

When there were midwives who did not fall in with the customs and sentiment surrounding 'the second midwife' and preferred to work on their own, it was generally seen as a problem.

"And midwives who haven't done this [accepted the custom of having a second midwife], they're not here anymore. Except (gives a colleague's name), you can't go in her room, it's a real problem, and we've been trying to tackle it, but it's --- it doesn't work. She's not letting you in the room. If she's letting you in, you're not allowed to talk. […] But that's a bit tricky, em, but, otherwise, yeah, all the midwives that haven't been able to cope with the fact that someone was coming

---

[42] The Mc Roberts position involves a woman abducting her legs and pulling them up towards her chest. It is thought to change the internal dimensions of the pelvis to allow descent of the fetus during the second (pushing) stage of labour.

into their delivery, […] they haven't coped with that and they've gone." AMU MW 1.3

"I know that some midwives here don't. They would not want anybody to come in until the actual baby's nearly birthed." AMU MW 1.6

"Midwives don't do birth on their own here --- they always have a second midwife, and that's not only as an assistance --- but that's also to observe --- and to give key feedback. +" FMU MW 2.15

7.1.3 Conclusion

Findings of Chapter 6 confirmed that the a priori defining attribute themes reflected midwifery practices in the MLUs in ways that were expressed in the sub themes. The findings of Chapter 7 contribute new knowledge to add to the existing concept of midwifery led intrapartum care. Although these findings do not directly correspond with how MLU midwives enact the defining attributes, they represent interesting background information to the cases.

Figure 7.2 brings the finding of chapters 6 and 7 together, illustrating both the relevance of the a priori defining attribute themes and the contribution of the contextual themes derived through open coding. The importance of this study is its original contribution to existing knowledge through novel findings of practices in midwifery led intrapartum care settings gained from in depth exploration of both a priori themes, and themes which became apparent through open coding. For the a priori themes, the existing picture of midwifery led care has been reshaped by the study findings, whereas findings from open codes contribute to a more complete picture of midwifery led intrapartum care, through providing contextual detail. Such detail, to the knowledge of the researcher, has not previously been conceptualised in this way: providing environmental and circumstantial qualities of midwifery led intrapartum care.

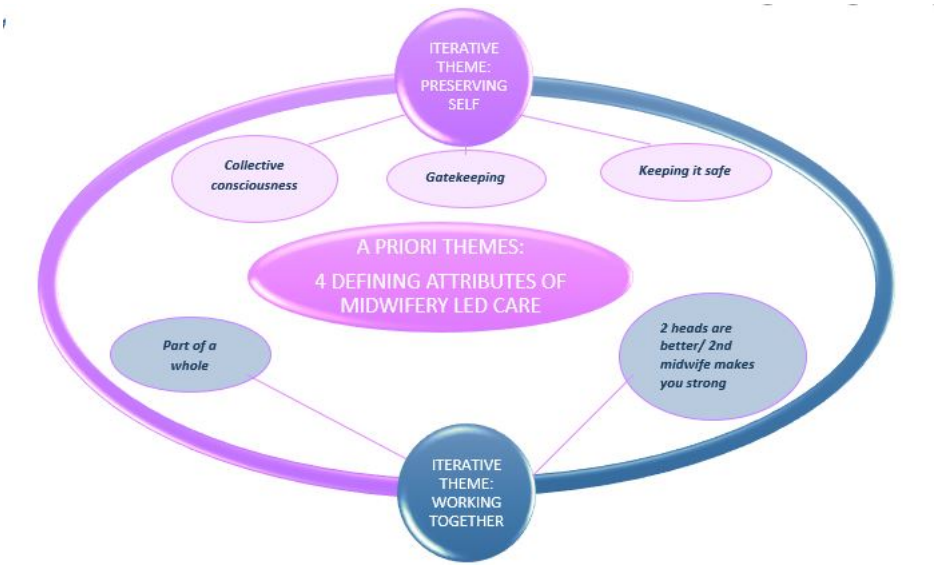

Figure 7-2 Showing central concept of a priori themes contained within and influenced by the environment of open coding themes and sub themes

Chapter 8 consists of the discussion of a priori findings (from Chapter 6), to include their relationship to extant knowledge. Discussions from open coded themes, and the unique insight they provide in analysing and understanding midwifery led care practices, are to be topics of planned future work. These iterative themes are embedded in a model, developed to represent the enactment of defining attributes of midwifery led care (Figure 8.6.1), demonstrating their value in addressing the research question.

Chapter 8 Discussion

8.1 Introduction

This study began with a concept analysis of the model of midwifery led care that resulted in four defining attributes being identified, illustrated in Table 8-1 below.

The midwife is the lead professional and acts as an autonomous practitioner	Midwifery-led care is associated with a particular ethos: the belief that childbirth is a normal life process. Midwifery led care encompasses a belief in women to give birth physiologically. Furthermore, midwifery led care involves promoting normality and taking account of women as individuals
Midwifery-led care is associated with supportive and trusting relationships with women encompassing continuity of care and/or carer and partnership. This is more apparent in midwifery caseload models	Midwifery-led care is woman centred and meets women's individual needs. There is recognition that women's choices should be respected and that they are the final decision makers

Table 8-1 The defining attributes of midwifery led care

The defining attributes were components of midwifery led care considered to be the exemplars of the model, representing what is quintessential in midwifery led care. Through focussed case study they led to the uncovering of midwifery practices, collective ideas, and challenges. The defining attributes were then explored through literature review to see how they were represented in existing literature (Chapter 3). The research conducted for the study set out to determine how the defining attributes were enacted in midwifery practice. Findings of the research have demonstrated that what the concept analysis indicated as being

intrinsic to midwifery led care were indeed present in the chosen cases and enacted in ways described in Chapter 6.

The findings also gave rise to inductively derived themes (explored in Chapter 7) demonstrating the additional practices embedded within the cases selected. These inductive themes signified how the study went beyond the picture of midwifery led care implied by the concept analysis. Incorporating the inductively derived findings widened the scope of the study and led to a more inclusive representation of the enactment of midwifery led intrapartum care being made visible. Thus, the study has not only shed valuable light on midwifery led practices, it has also satisfied the requirement of a case study to include 'several directions' so that 'a rounder, richer, more balanced picture of our subject is developed' (Thomas, 2011, p. 4).

The discussion chapter has several purposes. Firstly, it will summarise how the research findings for each of the defining attribute themes address the research question outlined in Chapter 1, illuminating the strategies and techniques that are the components of midwifery led care. In some cases, this has led to a more nuanced, qualified picture of the theoretical constructs that the defining attributes represent, as illustrated in the literature review (Chapter 3). Secondly, it will focus on what has emerged as novel illustrations of midwifery led intrapartum practice, thus presenting ways that empirical evidence differs from the theoretical construct. Thirdly, the chapter will outline limitations of the study and recommendations for further research; clinical practice, and midwifery education will also be considered. The study demonstrated that that the defining attributes of midwifery led car were convincing features of the case study findings. Each of the defining attribute themes will be discussed in turn. Names of session headings include the most significant concepts.

8.2 First Defining attribute: Lead professional, autonomy, and advocacy

8.2.1 Lead professional, expert, and autonomous

The findings of this study supported what the literature review identified as principles of midwifery autonomy. Particularly in midwifery led environments, midwives had the status of lead professional and autonomous practitioner. It is likely that MLU midwives also asserted this view, which stemmed from particularly persuasive rhetoric of midwifery practice. This rhetoric is incorporated into influential position statements and proposals put forward for midwifery legislation from authoritative sources such as the International Confederation of Midwives[43] (ICM) (2014, 2017). The Nursing and Midwifery Council's updated standards for midwifery proficiency (NMC, 2019) holds that midwives being the lead professional for women and babies relies on them assuming accountability and autonomy (NMC, 2019:14). Similarly, in 2010 the 'Midwifery 2020'[44] working group in its vision for the future of UK midwifery gave recognition to the current workforce taking on the challenge of Woman Centred Care (WCC) in establishing themselves as autonomous practitioners (Chief Nursing Officers of England, Northern Ireland, Scotland, and Wales, 2010).

In the literature review (Chapter 3) leadership and autonomy were associated with enhancing midwives' ability to exercise control in organising their working lives and professional practices, characteristics which have been referred to as midwifery agency (Walsh and Devane, 2012). Findings from the current study went further in

[43] The International Confederation of Midwives (ICM), supports midwifery associations such as the UK based Royal College of Midwives, in 121 countries worldwide.

[44] The Midwifery 2020 programme was set up in 2010 to investigate the contribution of midwifery to maternity services for women, babies and families across the United Kingdom.

revealing that it was distance from the 'host' maternity service and obstetric unit which strengthened MLU midwives' opportunities to be autonomous, and act according to a collective belief that straightforward birth was the norm. The lack of routine presence from other professionals in their work settings protected and preserved the ethos of midwifery led care that the midwives were committed to. Decisions about their practices, in situations of normality, were not subject to immediate surveillance or input from obstetricians or senior midwives who, working from a different philosophical standpoint, may have challenged those decisions. Although not completely eradicated therefore, distance limited the influence and the dominance of obstetric/medical philosophies of care as discussed by Hunter (2005), O'Connell and Downe (2009) and Walsh and Devan (2012). Distance also made it possible to subvert the expectations imposed on them as employees, for instance by disassociating themselves from the influence of clinical guidelines (despite the MLU midwives being no less obliged to take such guidance into consideration than midwives working in other settings). The idea that midwifery led units promised professional freedom for midwives has also been explored by Thorgen and Crang-Svalenius' (2009). Their qualitative study investigated the experiences of nine midwives working across three midwifery led birth centres in England. Autonomy was facilitated by the absence of obstetricians and other doctors such that the midwives felt completely free to make clinical decisions about care. Findings from the current study, therefore, are aligned with previous literature in concluding that the working environments of the MLUs promoted autonomous midwifery practice.

In wider literature, there have been several attempts to critically apply the theory of street level bureaucracy to explain midwifery practices and comparative midwifery freedom (Walsh, 2006; Finlay and Sandall, 2009; Scammell and Stewart, 2014; Russell, 2018). The core elements of 'street level bureaucracy' (Lipsky, 2010) usually applied to public service workers directly responsible for delivering public policy objectives (for example, health, education, or welfare policy), who had considerable discretion in how the services were experienced by users of the

services. Lipsky (2010) described situations where public service workers (street level bureaucrats) were tasked with responding to increasing demands from users of those services whilst managing chronically inadequate resources. Rather than being paralysed by an unwieldy, static problem, Lipsky (2010) considered that public service workers operated along 'a continuum of work experiences ranging from those that are deeply stressful and where the processing of clients … (was) … severely under resourced, to those that provide a reasonable balance between job requirements and successful practice' (Lipsky, 2010: xviii). Finlay and Sandall (2009) critically applied the theory to midwifery. They considered that despite working within the bureaucratically organisational structure of the National Health Service (NHS) where most UK midwives are employed, philosophies of care that promoted client centredness (rather than standardised care), continuity, and advocacy allowed midwives to prioritise the needs of individual women over the needs of the organisations. Their analysis is useful in explaining how MLU midwives of the current study imagined the differences between them and their midwifery colleagues who were more centrally positioned within the maternity services, closer to the administrative functions. MLU midwives hypothesised that greater freedom (and autonomy) was possible in their more peripheral settings, and greater possibility of using their discretion in making decisions about how they practised.

Findings of the current study were consistent with the vision of midwifery expertise presented in the literature review. Through being the professionals with overall responsibility, the MLU midwives recognised that expertise in clinical skills and experience working as a midwife were the vital characteristics for running their service. Their responsibility was in caring for healthy women[45] They valued knowing

[45] Descriptions of the client group vary in literature between normal, straightforward, healthy, and low risk

the appropriate clinical steps to take in providing care, and understanding the physiological processes of birth to accurately assess progress in labour using the minimum of interventions. MLU midwives also valued working with experienced colleagues who would be familiar with the multiplicity of situations that could occur during a woman's labour, who were self-reliant and reliable to others. In their somewhat isolated geographical locations, and being the sole professional group present, each midwife needed to be able to pull their own weight without being supervised and their peers needed to trust the standard of care they were giving.

Research conducted by Simpson and Downe (2011) investigated the meaning of expertise for a sample of midwives employed at two midwifery led and two consultant led units. The research found three possible expressions of midwifery expertise: physiological, technical, and integrated. The physiological was optimised and enhanced in low risk environments where normal birth was the usual outcome, but also contributed to the success of those environments. The technical was expressed where practitioners flourished in higher risk environments, displayed high level, and sometimes specialist technical abilities and were comfortable and confident with using technological equipment and medicalised processes. Finally, integrated expertise occurred where participants could operate in both types of settings, uninfluenced by the environment of the setting. Applying these conclusions to the findings in the current study, it is evident that the focus of the midwife participants was in developing physiological expertise. They were also pragmatic and experienced enough to know that it was important to possess technical skills for those situations when birth did not follow a straightforward path within their familiar settings. Thus, their range of expertise and experience was most beneficial within and for midwifery led environments, and conversely, midwifery led environments benefitted most when the midwives employed to work in them were equipped with physiological expertise (Downe and Simpson, 2011).

If autonomy, and the ability to exercise control over working lives, was at least partially mediated by MLU midwives claiming expertise over their surroundings,

what the current study adds to the understanding of midwifery led care is that MLU midwives put a premium on experience and expertise (enacting this, for example, by attempting to steer newcomers' practices). They regarded it as a major advantage, a selling point of their service. The midwives could claim custodianship of normal childbirth, in the sense of having practices and a philosophical position which facilitated undisturbed labour. Thus, if their expertise or ability to provide safe care was questioned by external agents or maternity service management this was seen as an existential threat. Pedahzur et al. (2009) discussed threats as being existential when they posed a danger '… to the very existence of an organism or institution, or when they entail radical change' (Pedahzur et al, 2009).

An additional finding of this research only briefly addressed in the literature is that midwives questioned the appropriateness of asserting themselves as being autonomous in their day to day connections with women. In this perspective, autonomy was a necessary principle when dealing with other maternity professionals. Autonomy meant that midwives used their authority to determine scope of practice when working within hierarchical maternity systems. Midwives were aware of their position in the overall organisation. They believed that when compared with the host unit, they were considered as inferior, therefore lower in the hierarchy. As such there was a political component to midwifery. It was described as 'a sisterhood' and 'a movement', experienced as a continuous struggle to justify their midwifery practices and uphold the ethos of childbirth as a physiological process requiring a non-interventionist approach to care. 'Struggle' or 'conflict' as characteristics of midwifery experience have been illuminated by Blaaka et al. (2008) and Hunter (2004). Blaaka conducted phenomenological research into the experiences of skilled midwifery and interviewed seven hospital midwives in Norway. Their struggle arose from wanting to express midwifery principles of care, i.e., individualised treatment, yet existing in settings where the ideology of biomedical standardised care dominated. Hunter's (2004) study sought to discover how emotion was managed by students and qualified midwives in a range of typical work settings. She found that medicalised hospital environments

were the most emotionally difficult ones. Midwives working in these settings experienced conflict of having their philosophy of individualised, woman centred care unfulfilled (2004). The current study found that in the secluded environments of the MLUs, where midwives were protected and supported by likeminded people, it was not necessary to defend the autonomy and authority of the midwifery position. MLU midwives were prepared to concede autonomy to women, reviving it when engaging with external forces. There is limited exploration of this phenomenon in existing literature. In Cronk's discussion of midwives as professional servants (2010) she suggested that when connections between midwives and women are based on relational or continuity models power and authority shift from midwife to woman. Midwives, therefore, could provide services shaped by women's choices and acknowledging of their autonomy. Irving's doctoral thesis (2018) focused on the experiences of UK based independent midwives[27]. In her study, independent midwives considered professional autonomy to be a key component of their working lives, in contrast to the constrained version of autonomy available to NHS based midwives. In their relationships with women clients, however, the independent midwives were more concerned with women's autonomy than their own. The findings of the current study, therefore, shed light on how MLU midwives may downgrade the need for autonomy when working in non-threatening environments where their defences can be lowered.

8.2.2 Advocacy

Although advocacy was not an obvious component in the literature of the first defining attribute, the findings for this study demonstrated that what was required for midwives to enact their roles as lead professionals, exercising a measure of autonomy, was a commitment to honour the choices women made in childbirth, and to represent them to others. Paradoxically, however, the findings also revealed

that for this group of midwives, living up to the ideal of being a woman's advocate was problematic in their day to day working lives.

As a concept, advocacy appeared to be one of the components of a midwife's role that was considered self-evident, in that occupying space as the lead professional brought with it the ability, opportunity and desire to negotiate on behalf of women, including where there were conflicting opinions. Advocacy appeared as a principle of care that the participant midwives aspired to and wanted to enact in their practice. Midwives are required to act as women's advocates from the point of registration (NMC, 2019). The NMC describes obligations arising from advocacy in several ways, including supporting women whose decisions do not accord with clinical guidance (2019). At the same time there is an expectation that midwives (and nurses) support and respect women's decisions of whether to accept care and treatment (NMC, 2015 or 2018).

Concept analyses of advocacy within healthcare settings contribute to a greater understanding of midwives' positions. Baldwin (2003) and Xiaoyan and Jezewski (2007) concentrate on advocacy within nursing practice. Vulnerable or sick patient groups to whom nurses usually provide care may not be strictly comparable with healthy women experiencing a 'normal' life event, the focus of the midwifery led units. However, the findings of this research study suggest that it is appropriate to look to these works to explain participant midwives' experiences of advocacy. Both concept analyses identified defining attributes of advocacy that correlate with MLU midwives' perspectives. 'Apprising', 'valuing' and 'interceding' (Baldwin, 2003) and 'safeguarding patients' autonomy' (Xiaoyan and Jezewski, 2007) are reminiscent of the midwife participants' use of advocacy in negotiating on behalf of women. Thus, in the current study, midwives interpreted advocacy as the need to represent women when encountering a range of others: colleagues inside and outside the MLUs and the women's own family members.

In this way, as Kennedy et al. (2004) suggest, midwives were involved in the 'orchestration of an environment of care' because they used their advocacy practices to create, for the woman, an 'environment in which the women's desires were met' (Kennedy et al., 2004). Kennedy's narrative analysis looked at scenarios of midwifery practices and women's experiences of childbirth provided by 14 midwives and four childbearing women from across the United States. The midwives were predominantly certified nurse midwives who worked in hospitals, birth centres and homes. The scenarios typically included vignettes and stories created by them. Advocacy was one of two concepts considered to be the basis of orchestrating the environment. Two significant aspects of the advocacy described were midwives supporting women in the choices they made for childbirth and aligning their choices with what they themselves considered to be safe. This implies that a synthesis of views was reached which both parties found acceptable.

What is not clear from Kennedy's study (2004) was what happened where midwives and women held different views. A finding for the current study was that advocacy could also take midwives into the less comfortable territory of going along with women's wishes even though they believed the wishes might lead to unsafe situations. The MLU settings overtly legitimised the authority of women's decision. Although ongoing clinical concerns during labour usually mandated transfer to the obstetric unit, MLU midwives were invested in following through with the promise of accepting women's choices. What was clear, therefore, was that midwives recognised their precarious position and possible lack of protection from the criticism of other professionals, in advocating for women. Thus, MLU midwives lived with a degree of anxiety because it was not always possible to rectify the situation and their sense of personal and professional security could potentially be endangered by women's decisions. The example of managing an obstetric haemorrhage on the FMU (Chapter 6) led the midwife to consider her own vulnerability: that of being in a relatively isolated location with limited support and a potentially life-threatening condition. Thus, the need for protection and someone 'having her back' was identified as important in an MLU setting. Although MLU

midwives from both sites were confident that colleagues 'had their backs', and felt allegiance with clinical leaders closely connected to the birthing units, they also desired support from colleagues external to the midwifery led units, and wider midwifery management. However, the wider maternity team's obligations, evidenced in clinical guidelines, to support the MLU in urgent or emergency situations was not necessarily relied on by MLU midwives. As Finlay and Sandall (2009: 1233) suggested, advocating for women was potentially "a difficult path for any worker to tread".

The challenges of advocacy have been examined by Feeley et al. (2019) in their meta ethnography of midwives' experiences caring for women who chose to decline medical interventions. Three of the five included studies explored the views of intrapartum care midwives living in the UK (Cobell, 2015; Symon et al., 2010; Thompson, 2013). Only one of these studies focussed on experiences dealing with actual adverse outcomes, rather than women presenting with risk factors (Symon et al, 2010). Symon et al.'s study considered management and decision making of UK independent midwives in the cases of 15 perinatal deaths (2010). Although the meta ethnography discusses the independent midwives' 'strong commitments to maternal autonomy' (Feeley et al., 2019; p 57), the original study (Symon et al 2010) gives a more nuanced picture of the difficulties faced particularly when transferring women to hospital or going through investigatory processes. The findings of the current study contribute to understanding midwives' experiences of following through with women's choices in problematic situations, but also indicate how fundamental the relationships between MLU midwives and the wider maternity teams are in supporting them to fulfil this basic part of their role.

8.3 Second defining attribute: Quality relationships and communication with women

8.3.1 Relationships

The findings of this study present persuasive evidence of MLU midwives valuing quality relationships with women. Their investment in these relationships was observed as intentional, multifaceted, and complex. Striving to make effective connections with women served several purposes for the midwives. It helped when giving intimate and emotional care and support. In cases of urgency or emergency, it meant that women were more likely to trust the midwives' judgements and comply with their recommendations to resolve the situation. On an emotional or spiritual level, midwives sought good relationships because it made work more meaningful and rewarding.

The literature review determined that one of the keys to developing meaningful relationships was through the 'continuity of care' model of midwifery practice. However, the findings of this study question the absolute need for continuity to establish good relationships between women and midwives in intrapartum care. Findings also challenge the idea that without knowing each other beforehand, the connections between the two parties cannot lead to 'the development of trust or … [creation] … of mutual knowing and understanding' as suggested by Irving (2018). Nevertheless, the literature review found that continuity of care was the vessel through which positive outcomes of childbirth were actualised (e.g., less use of pharmacological pain relief) (Sandall et al., 2016). Sandall et al.'s influential review of 'measurable' outcomes of midwifery models of continuity was supportive of both 'case-loading' and team continuity (2016). Both encompass a 'known midwife' arrangement for antenatal and postnatal care. The team midwifery allows for women to receive intrapartum care from either of the midwifery team members, with whom the woman would at least have met during her pregnancy. Thus, women are cared for in labour by a midwife who is familiar to them.

Neither of this study's cases of midwifery led services consisted of continuity models of care (see case profiles, Chapter 6). The MLU midwives acknowledged that in the majority of situations, women did not have longstanding relationships with the midwife who attended them in labour. Though they were aware of the significance of continuity in maternity policy, there were mixed opinions about whether the lack of an existing relationship represented a significant disadvantage. Empirical experience told them that despite operating in an 'unknown midwife' system, other factors existed which conferred benefits on women using their services. Furthermore, the MLUs were associated with successful physiological birth and auditing their services demonstrated these benefits[46]. Evidence from research confirmed the efficacy of midwifery led intrapartum care for straightforward, 'low risk' women in the England (Hollowell et al., 2011). Despite Irving's claim (2018), the MLU midwives, in using 'rapport' and 'relationship' interchangeably, understood their care as representing relationship building with women and families.

The MLU midwives circumvented the problem of prior contact with women and lack of continuity, by enacting purposeful strategies, discussed below. Thus, the nature of their connections with women compensated for not having known them during pregnancy. The literature review identified quintessential components of relationships between midwives and women which underpinned continuity of care and contributed to its effectiveness. These components included collaboration,

[46] An audit of the FMU was available during the period of data collection for this study. The audit reflected outcomes for 2015 and demonstrated high levels of vaginal birth and water birth. For women who started their labours at the FMU, 89% achieved spontaneous vaginal birth. 8% had instrumental and 3% caesarean sections after transfer to the host obstetric unit (OU). 31% of nulliparous and 4 % multiparous women transferred to the OU whilst in labour

flexibility, being attuned to women's individuality, trust, respect, being present, and providing a calm context for the birthing process. The findings both reflect these components and enrich the picture given of midwives engrossed in the practice of relationship building. Importantly, the findings demonstrate that effective relationships are possible where intrapartum services are not organised around a continuity model. The findings also reflect aspects of partnership relationships presented in the literature review (Boyle et al., 2016) which are relevant to care in labour. Hence, supporting autonomy, and respectful, trustworthy negotiating characterised MLU midwives' practice. The findings revealed that the MLU midwives behaved in ways equivalent to their counterparts on Boyle et al.'s study (2016) with respect to time. The MLU midwives created the same opportunities for women to have as much time physiological labour and birth needed, as Boyle et al.'s (2016) Birth Centre midwives did in giving time for women in antenatal appointments.

In enriching the picture of midwifery practice, this study has illuminated how MLU midwives made use of purposive strategies to enhance therapeutic connections with women. The first of these consisted of treating them like personal family members. The second was demonstrated through proactively welcoming birthing partners or companions.

8.3.1.1 Treating women like family

This study's findings present a unique insight into MLU midwives' aspirations to provide a standard of care to women worthy of a close family member. Direct and exploratory references in existing literature to midwives' desires to treat women as family are lacking. Therefore, in presenting MLU midwives' intentions for sustaining relationships, the current research proposes a deeper aspect to the midwife – woman relationship which may transcend the notion of partnership relationships with women. The findings identify caring, nurturing and mothering as behaviours

and emotions midwives were prepared to incorporate into their practice, which coincide with the 'emotion' attribute of compassionate midwifery defined in Ménage's concept analysis of the term (2016). Ménage (2016) discussed women's desires for midwives to be kind, emotionally connected, empathic in noticing how they are coping with their experience, and for midwives to seek caring relationships with them.

Irving (2018) discussed how the independent midwives in her UK based study valued feeling part of the families they were providing care for, and how this state of inclusion enhanced the pleasure they derived from their work. In Bradfield et al.'s Australian study (2019) the phenomenon of being 'with woman' was explored from the perspectives of midwives caring for women in labour. They conducted individual interviews with 31 midwives and explored their perceptions of what being 'with woman' entailed. Of the study's three main themes or collective characteristics, one relied on midwives being in partnership with women. The desire for partnerships and connections with women was felt by midwives working with both known and unknown midwife models. Findings of the current research reflect and validate the impetus felt by midwives in Bradfield et al.'s study (2019) to build effective connections with women. However, it is clear from the literature review, and wider evidence that the unexpected finding of MLU midwives' willingness to invest emotions and behaviours normally confined to family members signals the need for further exploration.

As well as regarding women as family members, this study identified midwifery attitudes of 'being in service' to women. 'Being in service' equated midwives with 'ladies in waiting': providing support, being present and available at all times, and centring women's needs beyond what treating them like family entailed. Cronk (2010) discussed the historical demise of midwives as 'professional servants', thereby being at liberty to serve women's needs in this way. She argued that only in independent midwifery was it possible to adopt this position with women. Midwives employed within the National Health Service were subject to their

employee demands and obstetric power, eroding their freedom to serve women's interests. The finding from this research, however, showed MLU midwives operating in environments which were accepting of professional servant roles, as well as centring the needs of women in their care. The professional servant role has parallels with what Graber and Mitcham (2004) concluded in their US healthcare based qualitative study of the practices of clinicians who identified as being compassionate. Through their findings, they devised a 4-tiered model of patient clinician interactions. The deepest degree of intimacy and connection was found in the 'personal/feeling' and 'transcendent' levels, both of which led to concern for the patient to be at least equal to or greater than concern the clinicians had for themselves. The possibility that midwives actively subordinated themselves to the women they provided care for is another factor of relationships in the MLUs that is not presented in wider literature.

8.3.1.2 Caring about birthing partners

The current research also revealed MLU midwives positively and intentionally putting birthing partners and companions at ease, making them feel welcomed and accommodating numbers that they believed would not have happened in OU settings. The midwives encouraged and guided partners in supporting women. In enacting 'supportive and trusting relationships'[47], they were eager to articulate how they took account of birthing partners and prioritised their welfare. Though concern for wellbeing and wanting to make partners feel welcomed influenced midwifery practice, the midwives were also aware that positive connections with

[47] 'Supportive and trusting relationships' is embedded in the third defining attribute of midwifery led care.

partners enhanced their own relationships with women. As Symon et al. (2011) pointed out, the expectation that birthing partners would be spending significant amounts of time in the birthing environment, in close proximity with birthing women and midwives, made them important for the midwife-woman relationship. The experiences of and midwifery attitudes towards birthing partners have been evaluated in other studies (Bohren et al., 2019; Bradfield et al., 2018; Sosa, 2017; Symon et al., 2011). Bohren et al.'s qualitative evidence synthesis presented the different perspectives of labour companions held by women, partners, doulas and health professionals. They analysed 51 studies from a range of mostly high-income countries. The evidence synthesis put forward beneficial effects of birthing partner presence: being an intermediary for information sharing between woman and midwife, advocating for women, and giving them physical and emotional support. Some of these activities were associated with partners working with midwives to serve women's needs in labour. Sosa's (2017) ethnographic study of midwifery led birthing environments also found evidence of collaboration between midwives and birthing partners. Undoubtedly, the MLU midwives of the current study also valued partners and recognised their value in supporting women both behaviourally and emotionally. The current study, therefore, compliments existing literature by illustrating practices midwives used to bring partners into the fold. It also suggests an underlying commitment by midwives to investing emotionally with partners for altruistic reasons. This paralleled treating women as family members or being willing to adopt roles of professional servants. and demonstrates the behavioural and emotional effort midwives expended in securing relationships.

8.4 Third defining attribute: Believing childbirth is a normal life event

The discussion of this defining attribute starts with the idea of MLU midwives having an overarching belief in normal birth being what most women can attain. The belief is supported by different factors, historic maternity policy and

contemporary research evidence being examples of them (House of Commons, 1992; Hollowell, 2010). This section, therefore, examines how belief in achievement of normal labour influenced participant midwives' ways of knowing and decision--making about appropriate midwifery practice. To do so, it addresses the main themes identified in the findings chapter: knowing and understanding normality, and balancing action and no action, and introduces concepts that are helpful in explaining them (organisational culture and models of health). In doing so, it demonstrates how the research is positioned with respect to wider theory.

The literature review highlighted that belief in childbirth being a normal life event was a foundational quality of midwifery care (Sandall et al., 2016; Davis, 2010; Russell 2007; Anderson, 2003; Kennedy, 2000). This study's findings demonstrated how the MLU midwives continued to embody that belief. They were committed to 'normal' labour and birth, or 'normality'. The focus of their practice was providing care in situations of normality. Their frame of reference determined which women were admitted (normal pregnancy), shaped the environment as being one where normal birth was promoted, and defined what they regarded as the desirable outcome (physiological birth). As with ideas of advocacy and autonomy, the fact that such beliefs about childbirth were considered integral to the midwifery profession is demonstrated elsewhere. The recommendations of two influential maternity services reports, Winterton (House of Commons, 1992) and Cumberlege (DH,1993) which contribute to the background of the current study, advanced pregnancy and birth as physiological events or normal processes that happened for a large proportion of women. Normal birth was regarded as a 'manifestation of health' (House of Commons. 1992). The view of childbirth contained in these historic reports went on to influence maternity services policy in the decades that followed (Welsh Assembly Government, 2002; Department of Health, 2007; NMC, 2009; Chief Nursing Officers of England, Northern Ireland, Scotland, and Wales, 2010). Childbirth being a normal life event, care of healthy 'normal' women could be seen legitimately as the domain of midwifery practice. Conclusions from the 'Birthplace in England' study (Hollowell et al., 2010) indicated that healthy low risk

women giving birth in a midwifery unit were likely to experience fewer obstetric interventions than if they had chosen an obstetric unit as a place of birth, whilst not resulting in worse outcomes for their babies. The findings were suggestive of labour and birth being inherently straightforward and uncomplicated. From a global perspective, the International Confederation of Midwives refers to childbirth as a 'physiological life event', achievable for most women (ICM, 2014). The Royal College of Midwives incorporates in its perspective of midwifery led care, the understanding that 'pregnancy, birth and the postnatal period are normal life events for a woman and her baby' (RCM, 2016). Midwives in the current study valiantly maintained this vision of normality. They referred to the importance of their 'ethos', or 'philosophy', or 'expectations' of women. Through information giving, they promoted ideas to women about their capability to manage early labour in their own homes (Document 1.02; AMU research site, undated). They considered that their beliefs about childbirth were important and could affect what happened during labour and birth. They distanced themselves from ideas that childbirth could only be regarded as normal in retrospect.

This stance was taken despite national and international debate around the time of data collection at the FMU. In late 2017, a public discussion began about the appropriateness of the midwifery profession positively promoting normal birth. It came about because an article in The Times newspaper applauded the Royal College of Midwives for relinquishing its 'Campaign for Normal Birth'[48]. The then Secretary of State for Health, Jeremy Hunt, involved himself by opining on social media in favour of normal birth no longer being generally regarded as a desired

[48] The Times article of the 12th August 2017 'Midwives back down on natural birth', was mirrored in The Guardian and the New Scientist. Jeremy Hunt tweeted words to the effect that ending the campaign would assist in the government plan to halve neonatal deaths and injuries by 2025.

outcome. In his view, the RCM's 'new' position would save babies' lives. Although the RCM claimed that The Times article misrepresented its intentions, the publicity prompted great interest in the language and descriptions used to define normality, and whether midwives were guilty of overemphasising the achievement of normal birth at the expense of safety. In short, normal birth came to be challenged, and somewhat ostracised, with those who promoted it seen by some to be dangerous radicals.

Dahlen, an Australian midwife and researcher, framed the outpouring of criticism within the phenomenon of 'normal birth in a post truth world' (2017). In an article of the same name, she pointed to a contemporary definition of 'post truth' whereby 'objective facts are less influential in shaping political debate or public opinion than appeals to emotion and personal belief' (Oxford English Dictionary, 2019). MLU midwives who engaged in staff-room discussion about this topical issue were not deterred from their confidence in normal birth, nor inclined to alter the language they used to define it.

In a similarly recent period, however, it appears that the underpinning belief about childbirth being a 'healthy life process' or 'normal life event' has begun to wane. The latest national review of maternity services, 'Better Births', adopted as government policy, focuses on 'personalised' family centred care, i.e., care designed to fit the needs of individual women and families (Department of Health 2016). The review envisages that women will experience continuity of care facilitated by small teams of midwives, whilst being referred, as necessary, to other professionals. Thus, far from being 'a normal process which occurs during the lives of the majority of women' (House of Commons 1992: v) or considered the case that 'for the majority of women, pregnancy and birth will be uncomplicated' (Department of Health, 1993: 12), attention has been drawn to increasing complications in childbirth and the importance of multidisciplinary team working in order to service increasingly complex needs (Department of Health, 2016). With 'Better Births' there is no declaration of belief in the inherent normality of childbirth

that resembles or supports what midwives in the current study considered incontrovertible about the nature of pregnancy and birth. To understand what underpinned their belief it is instructive to consider the knowledge that they called on to inform practice.

8.4.1 Knowing an understanding normality; authoritative knowledge

The literature review identified that midwifery led care supported multifaceted sources of knowledge. Midwives drew from experience and clinical judgement, obstetric knowledge of physiology, and knowledge gained from observing and interacting with individual women that was appropriate for unique circumstances (Guiver, 2004, Davies, 2010). In comparison, MLU midwives identified intuition, experiential knowledge, biomedical and research-based knowledge such as that associated with clinical guidelines, and knowledge of women's physiology as being valid contributors to the way they understood and interpreted individual women's situations. Thus, the epistemological leanings of the midwives in the current study reflected what was shown in the literature review. More importantly for the research question, however, the findings of this study went further in explaining how participants were creative in seeking solutions and explanations that best suited the different clinical situations they found themselves in.

This study also demonstrated how pragmatic MLU midwives could be about the knowledge they called on to inform their practice. They moved seamlessly between, for example, relying on intuitive feelings about how a woman's labour was progressing and incorporating practices recommended in standardised clinical guidelines. They mobilised understanding of such entities as oxytocin, physical environment, and effects of gravity and movement on fetal descent. As with Guiver's findings (2004), the MLU midwives depended on different paradigms of healthcare to respond to women's individual experiences of labour and in their continuous assessment of labouring women.

There has been longstanding interest in midwifery perceptions of intuition. It is almost uniformly heralded by midwifery sources as a fundamental component of midwifery knowledge (Davis Floyd & Davis, 1996; Parratt and Fahy, 2008; Fry, 2016). Davis Floyd and Davis (1996) described the process of intuitive practice occurring when midwives were alerted, through physical visceral sensations and experiences, to information about a woman's condition. Midwives' physical sensations and experiences happened before the same information reached conscious thought. Intuitive impulses meant that midwives acted before they were conscious of their intentions to act. The prerequisite for intuitive practice, however, was that midwives had a deep connectedness with the women they cared for. Achieving connectedness required a mind clear of thoughts and concerns, hence the ability to be receptive, present, and focussed on the signs and symptoms women elicited during the progress of their labours. Fry (2016) explored this emotional aspect of midwifery work in her doctoral study of midwifery intuitive knowledge. Fry (2016) also discussed the need to establish connectedness with women as a way of tuning in to them and their needs. Parratt and Fahy (2008) included intuition as one of the means by which 'non-rational' aspects of life could be described. They put forward the idea that midwives mobilised 'non-rational' ways of thinking, of which intuition was an example, to support women in accessing their own internal capacity to give birth. The non-rational perception enabled them to accept circumstances and events in a woman's labour as not necessarily unsafe, even though they did not fit into the rationalist view of being safe. In this way, the non-rationalist perception rejected the tendency of rationalist thought to present different options as dichotomies, and therefore existing in opposition to each other. Parratt and Fahy (2008) illustrate this point with the safe: unsafe dichotomy, which is firmly embedded in the dominant rationalist worldview of obstetrical practice. Thus, and according to this worldview, a person or situation is either safe or unsafe. Obstetric units with their technology driven environments were conceptualised as safe places for childbirth to occur. Childbirth occurring in distant environments such as in women's homes or midwifery led units were unsafe for women and babies. As

Bonet de Viola and Espinoza (2020) point out when discussing the influence of rationalism in modern childbirth, where safety is thought to apply only to one set of circumstances, interventions and standardisation of care are overvalued in order to bring all in line with those circumstances.

The fact that intuition featured as a driving force for the MLU midwives' practice in this research is also illustrative of the separation they felt from obstetric unit routines. Operating outside of the obstetric way of thinking made it possible for midwives to accommodate women progressing in labour in ways that were peculiar to them, without regarding such peculiarities as problematic. The importance of these explanations of intuitive thinking to this study is in clarifying how participant midwives from both cases were willing to acknowledge freely their confidence in intuition as one of the legitimate and authoritative sources of midwifery knowledge.

8.4.2 Balancing action and no action

The findings of this study gave weight to midwifery led care being associated with judicious and careful decisions about intervening in childbirth, a characteristic also found in the literature review. The MLU midwives displayed their understanding of balancing action and inaction, enacted by deliberate and conscious inactivity, watching women in labour closely and waiting for events to develop. However, the study's findings enhanced the picture given by the literature review by demonstrating the finer details of what midwives did in caring for labouring women. What became clear was the trade-off midwives made with respect to measures taken to intervene in labour. It was not that midwives never considered intervening; rather, they critically evaluated using one intervention in order to avoid a more significant one in the future. They traded off what were considered small-scale midwifery actions against more obstetric technological practices, with the aim of nudging labour back to normal. Whilst interventions in childbirth have

been evaluated for their effects on outcomes such as morbidity and women's satisfaction, there is little in the literature that addresses the specific midwifery skill of strategically weighing up the actions available to them in the context of a woman's individual circumstance. This skill was crucial in revealing how they enacted belief in childbirth as a normal life process, targeting care towards women in their individual states. The current study, therefore, is valuable in Illuminating this dynamic midwifery activity.

The current study showed that belief in women's ability to give birth without intervention made midwives resist, at times, the pressure to 'rescue' women from the realities of the birth process, when women themselves wanted some relief, or change, to happen. In such circumstances, the findings suggest that midwives balanced advocacy for women's autonomy and choices with their own priorities. Thus, they negotiated with women about decisions in labour based on their beliefs in women's propensity for normal physiological birth and their own professional knowledge and judgement about the consequences of interventions. Resisting the urge to rescue women from the magnitude of physiological labour has received only limited attention in relevant literature.

The concept of decision making (and by association, women's choices) is discussed in association with the 4th defining attribute below, however, it is fitting at this point to look further at how the MLU midwives' beliefs about normal birth led them to interact with women. Porter, Crozier et al.'s exploration of midwifery decision-making with respect to the use of technology (2007) may be helpful here in critically discussing the interplay between labouring woman and midwives observed in the current study. From their study using observations of midwifery care and focus groups of midwives, Porter and Crozier et al. (2007) argued that for the UK, the era of the 1980s marked a transition, in the context of occupational control, from 'classical' or 'bureaucratic' professional approaches to decision making in healthcare to a 'new professionalism' approach. Whereas classical professionalism relies on the idea of professional as expert in control, invested with the authority

to make decisions about care without the need to the involve the recipient of that care, with bureaucratic professionalism it is the priorities of the organisation, embedded within its rules and guidelines for example, that modify clinicians' decision making practices. In contrast, the emergence of new professionalism, and new midwifery in particular, proclaimed the value of more egalitarian relationships between professionals. Porter and Crozier et al.'s (2007) findings, concluded that the consultation and collaboration associated with new midwifery professionalism was least likely to be used in making decisions about midwifery care, despite the midwives' strong affinity with the ideology of new midwifery.

As new midwifery is associated at least with advocating relational components of care (Scott, 2007), the findings outlined for the current thesis also demonstrate ideological commitment to egalitarianism. Unlike the midwives in Porter and Crozier et al.'s study, the environmental context of the MLUs in the current study favoured this way of working. Porter and Crozier et al. (2007) suggested that the variation in material contexts of midwifery practice was instrumental in shaping the complexities of decision-making processes i.e., midwives' decision-making practices were a product of their occupational or professional environment. Hence, in the context of the MLU case study sites, where material context of power relations favoured the social model of healthcare (deliberated on later in this chapter) midwives were freer to express the qualities of new midwifery.

As considered earlier in this chapter, midwives were also observed being hesitant or reluctant to intervene in labour (for example, with pharmacological pain relief, or oxytocics in the third phase of labour) in situations where women wished for such interventions. Such responses to women's' requests could simply be interpreted as signifying the 'classical' approach to decision making, as proposed by Porter and Crozier et al. (2007). This 'uneasy' situation is mirrored in Leap et al.'s work on how women receiving caseload midwifery care viewed their experiences of labour pain (2010). In their study, women acknowledged and accepted, in retrospect, the attempts to convince them of their ability to cope with labour

without exogenous pain relief. Leap et al. (2010) suggest that it was the existing relationship, and trust between women and midwives, which made it possible for midwives to act in this way. The MLU midwives' responses to women meant a commitment to physiological birth as a normal life process not requiring routine intervention, and confidence in their birthing environments as being among the most likely spaces for undisturbed, physiological birth to occur. Montgomery (1958), an American obstetrician practising in the 1950s, reflected on 'physiologic considerations in labour and the puerperium', which, though historical, are particularly salient here in mirroring the contemporary understanding of the MLU midwives:

'Throughout my medical life I have had a strong feeling for the physiologic in reproduction and have stated on numerous occasions on platform and in classroom that there is no more need to interfere with the course of normally progressing labor than there is to tamper with good digestion, normal respiration, and adequate circulation.' (Montgomery, 1958).

As Downe et al. (2020) point out, this enduring message is also present in current national maternity services guidelines, i.e., the cautioning against interference ('clinical interventions') in normally progressing labour (NICE, 2014). Thus, the MLU midwives of this study distracted women from seeking medical interventions in normally progressing labours whilst acknowledging the difficulty and struggle therein. Their energy was focussed on reactivating women's attention back to what Benet de Viola and Espinoza (2020) called the 'potential of childbirth as an event that is worth experiencing', or what Davis-Floyd (2001) referred to as the holistic practice of 'intervening to redirect the energies' so that interventions could be avoided.

8.4.2.1 Organisational culture as an explanation

The findings of this study enhanced the literature review by uncovering external factors that reinforced midwifery knowledge and beliefs. Although not explicitly named the MLU midwives were referring to their tacit understanding of organisational culture when they described how they worked together, what they collectively believed about childbirth, or how they attempted to control and assimilate new-coming midwives into their folds. Thus, differences between them and the OU arose because unlike what was possible there, the MLU midwives were able to maintain belief in normal birth within their safe organisational culture. The safe organisational culture was fuelled by midwives (and led to them) identifying with the MLU setting as a place where those beliefs could be reflected in their practices. The safe organisational culture also shaped their understanding of what needed to be in place to facilitate normal labour and birth.

Simpson et al. (2019) have pointed out that recent failings in the NHS have focussed on the issue of organisational culture because substandard and abusive collective practices were able to lead to poor outcomes for patients/women, including mortality and morbidity. The report of the public enquiry into the Mid Staffordshire NHS Foundation Trust (Francis, 2013)[49] referred to aspects of the 'common' or 'institutional' culture multiple times throughout its three volumes. Defective organisational culture was considered a significant cause of events such that one of the conclusions called for a 'fundamental culture change' (Francis, 2013: 11), as well

[49] Sir Robert Francis QC chaired a public inquiry into failings in care at Mid Staffordshire Foundation Trust in the period between January 2005 and March 2009. The causes of the failings in care were examined, including why none of the organisations responsible for regulating or managing the trust spotted problems sooner. The inquiry took place between November 2010 and December 2011. The report of the findings from the inquiry, which also included 290 recommendations, are widely referred to as the "Francis report".

as the need to develop systems for measuring organisational culture. Similarly, developing a deeper understanding of organisational culture was highlighted as an essential factor in the Morecombe Bay Investigation into maternal and perinatal deaths at Furness General Hospital (Kirkup, 2015)[50]. The investigation report highlighted the detrimental influence of a dysfunctional culture within the organisation. Organisational culture was therefore considered to be an important determinant in the outcomes, intended and unintended, that an organisation achieved.

O'Donnell and Boyd (2008) discuss organisational culture as providing a sense of identity to the individuals who inhabit a workspace. Identity comes from sharing 'legends, rituals, beliefs, meanings, values, norms, and language', which determine 'the way things are done around here' (O'Donnell and Boyd, 2008: 4-5). Thus, participants of the current research identified with each other, and the settings they occupied. They had beliefs about the value of the care they gave in facilitating normal childbirth. They had established norms, i.e., behaviours and standards of care they expected of each other. In particular, the norms made it possible for them to distinguish between themselves and midwives working in obstetric units. They recognised how aspects of the 'Model Case'' (Chapter 2) reflected their common practices. Thus, adjusting the look and feel of the birthing room by, for instance, dimming lights and making birthing aids available, or being receptive to the natural

[50] Dr Bill Kirkup was commissioned by the Department of Health to produce an independent report of an investigation into failings in maternity care at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The report highlighted where poor clinical care that led to the preventable deaths of one woman and 11 babies had not been investigated. Dr Kirkup made a series of recommendations, for both the University Hospitals of Morecambe Bay NHS Foundation Trust and the wider NHS.

variations in time taken by different women to labour and give birth, were also characteristic of MLU care.

Shein (1991) provided a detailed analysis of how culture comes to be embedded within a group, starting with beliefs and values about what the service is and how it ought to be. Over time, as experiences become common, and goals are successfully accomplished, the beliefs and values are validated, and eventually taken for granted. He discussed this process as resulting in a 'shared assumption set', which 'provide meaning, structure, and predictability to the members of the group' (Shein, 1991: 250-251). He presented three levels of organisational culture. The visible layer, or 'artefacts', consisted of physical environment, local rituals, and ceremonies. Underneath this layer consisted of 'values' (espoused philosophies and strategies), the deepest layer contained underlying assumptions, unconscious beliefs and habits. It is through revealing the basic underlying assumptions that organisational culture can be understood. Contemporary theoretical models of health and childbirth, discussed next, account for some of the underlying assumptions and beliefs that MLU midwives in the current study operated through.

8.4.2.2 Models of care – medical and social

The MLU midwives' perspectives can be positioned within one of two overarching models of health: the social, and the medical. There has been widespread commentary on the underlying differences between these models, and application of the models to a number of different disciplines and conditions within healthcare, such as disability, mental health, childbirth (Hogan, 2019; Shakespeare, 2012; Barber, 2012, Kitzinger, 2012). What follows, therefore, is a critical analysis of these models of health before exploring how the current study's findings can be explained with reference to these models.

There is a considerable body of literature on models of healthcare and their significance for childbirth. Cahill (2001) discussed the influence on medicine of the French mathematician and philosopher, Renee Descartes, who, writing in the 16th and 17th century Europe, was influential in changing the hitherto dominant orthodox Christian belief in the indivisibility of body and soul. He argued that the mind and body were two distinct entities. Hence, the mind, with its ability to think, did not rely on any place or require a material form in order to exist (Hatfield, 2018). In fact, the mind and body being separate made it possible to comprehend the existence of material things (Reynolds. 2019). Descartes believed that the human body was the equivalent of a machine and subject to the natural laws of physics (Cahill, 2001). Wagner (1994) contended that from the 19th century onwards these ideas began to dominate medical thinking. The workings of the human body were re-imagined as those of a machine including the onset and progression of ill health. The dominant European worldview came to identify with principles of classical mechanical physics. Once pregnancy became of interest to medicine, this view of the body was applied to the realm of childbirth. Analysing the culture of reproduction, Martin (1992: 54) expressed that 'the woman's body is the machine and the doctor is the mechanic or technician who fixes it'.

Van Teijlingen (2017) suggested that in general, health care professionals were socialised into operating according to the medical model. He had previously observed that models of childbirth, both medical and social, were expressions of the different ideologies associated with them (van Teijlingen, 2005). He discussed ideology as being the equivalent of political dogma. Medical and social models represented competing perspectives about human reproduction. The dominant medical model held its position by claiming a 'monopoly on knowledge'. The procedures, techniques, frames of reference, and methodologies used in arriving at evidence for medical practice determined technological developments in pregnancy and childbirth, and the justification for how things were done by its practitioners.

Within the medical model, childbirth is seen as a fundamentally risk-laden state. In order to address this inherent problem by minimising risk, thus making the process safer, medical control is critical (van Teijlingen, 2005). Minimising the potential risks to safe childbirth must occur by closely monitoring the recipients of maternity services, and intervening where ill health or potential disease is suspected. As prediction of risk is inaccurate, and it is not possible to select only those women who would actually benefit from medical interventions during the different phases of childbirth, all women should receive checks and monitoring. Similarly, when in labour, all women should have high technology equipment and expert clinicians available, ready to take over and correct any aberrations. Childbirth being normal only when it has proved itself to be the case is a rudimentary assumption of this worldview (van Teijlingen, 2017).

Bryar and Sinclair (2011) suggested how influential this model of childbirth has been in shaping women's expectations of maternity services. They proposed that women themselves have come to accept medical professionals as being in control, making decisions on their behalf, and being less concerned with psychosocial circumstances that do not directly affect the pregnancy. They suggest that women have tacitly approved medical preoccupation with effects of their health and lifestyle on the growing fetus.

The social model of health, by comparison, is influenced by the following premise: life and heath are positive forces through which the predominant experience is good health (Wagner: 1994). Feeling healthy is the normal state, with ill health or disability being transient adjustments. Walsh and Newburn (2002) also describe the social model of health as having a focus on wellbeing, with a positive view of health that includes mind, body, and interactions with others.

Davis-Floyd's (2001) further developed the theory of healthcare models and proposed three prominent paradigms, or frameworks, which have guided professional childbirth care: technocratic, humanistic (or biopsychosocial), and

holistic (2001). Whilst the tenets of the technocratic paradigm mostly reflect the principles of the medical model of childbirth it is her attempt to analyse the humanistic and holistic paradigms that clarifies the motivation and drives of the MLU midwives in the current study. Davis-Floyd identified 12 tenets of each paradigm which covered what was understood about the nature of being human. The humanistic model sees the mind and body being connected and representing a total organism. Healing, or returning to a state of wellness following ill health, took place because of efforts both internal and external to the organism. The holistic model recognised the 'one-ness' of body, mind, and soul, existing in an energy system which is ecologically linked with other systems and processes.

Applying this analysis of idealised models of health to MLU midwifery practices is useful in explaining how the MLU midwives were able to have confidence in rejecting essential tenets of medicalisation, such as the valorisation of technology. Consequently childbirth, in general, was conceptualised by the participants as part of daily human social activity, rather than as a medical, and potentially pathological, process in need of careful surveillance and control. The MLU midwives attached greater meaning to their own philosophy of care and understanding of the essential nature of childbirth.

8.4.3 Communicating

The findings of this study contributed an additional and novel element to the literature review. They uncovered how communication, particularly verbal, was used by midwives to enhance relationships with women. Through their communication styles the midwives offered positive reassurance and facilitated women's understanding of events in labour. The positive reassurances were delivered with non-verbal supportive gestures, or in positively reframing events in labour. Midwives encouraged where women had lost faith (not feeling the baby descend) and openly marvelled at basic signs of progress (such as rectal pressure).

They shared explanations with women and birthing companions and were mindful how they represented facts about the labour. These approaches were aimed at reassuring women of normality and preparing them for what was imminent. The actions of MLU midwives indicated their understanding of what Simkin (2012) asserted as women's sensitivity to suggestions that there may be problems developing in labour.

Scammel (2011) presented a comprehensive discussion of how midwives, despite aligning themselves to social, humanistic models of childbirth, could be unwitting agents of practices associated with hyper-surveillance of risk and medicalisation. She contended that even routine midwifery practices aimed at determining normality, such as vaginal examinations and how results were communicated to women, introduced uncertainty, thereby disturbing confidence in normal birth. The significance of Scammel's work to the findings of this research, is that the practices encountered in her ethnographic study included how the midwives communicated with women during their routine care. Though Scammel found midwifery talk to be problematic, and a contributory factor to pathologising birth, she also suggested that midwives' working environments could influence how risk is emphasised and amplified. The current research found midwifery collective consciousness and working relationships (to be discussed below) as well as lack of proximity to obstetric units established in both examples of MLUs. These factors at least emulate conditions experienced by independent midwives or by the Albany midwifery practice[51], mentioned in Scammel's work.

[51] The Albany Midwifery Practice operated a continuity of carer model of midwifery care from 1997 to 2009 in Peckham, South East London. The practice cared for an all-risk caseload of local women within the NHS. Women had continuity with the midwives and

This study has distinguished strategies used by midwives to develop effective and empathetic relationships in midwifery led care intrapartum settings when time is a critical factor. It has highlighted how midwives strive to treat women as close family members and include birth companions in their care. In discussing how some midwives may even regard themselves as subject to women ('ladies in waiting') findings of this study add to the understanding of how an 'unknown midwife' model of care and/or a non-independent NHS model can lead to a midwife-woman relationship being effectively enacted. This is especially relevant as underpinning current UK maternity policy is the drive for a known-midwife, continuity of care model for antenatal, intrapartum care, and post-natal care. This study, therefore, reveals an aspect of the midwife-woman relationship that could mitigate against the absence of a known midwife model, or continuity of care.

8.5 Fourth defining attribute: Women centred care (WCC) and decision making

8.5.1 Women-centred care

In comparison with the literature review, the findings of this research show that WCC was expressed through midwifery practices and behaviours rather than as a concept or philosophy of care. WCC was enabled by the relationships MLU midwives built with women. The relationships, discussed above, made it possible for them to be physically close and emotionally connected with women. There were indications of midwives' empathy towards women which led them to adapt themselves and their care to suit them. The findings gave a detailed picture of

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choice of place of birth. The midwives looked after over 2500 women, with a home birth rate of over 40for %, and a low perinatal mortality rate.

practices associated with WCC which were varied yet interrelated. Thus, midwives focussed intently on how labour affected women, midwives showed reciprocal, mirroring behaviours, and midwives adapted or worked around women to avoid disturbing labour.

The literature review emphasised the centrality of WCC to midwifery practice. Women were satisfied with care if midwives made them their priority, supported and communicated with them according to their individuality. The review highlighted the impact of midwifery practice and attitudes in providing WCC. Midwives were responsible for facilitating reciprocal relationships which included shared responsibility for making decisions. WCC meant midwives were conscious of the birthing environment and how it aligned to women's choices, and knowledgeable and willing to share their knowledge. That MLU midwives had awareness of such factors as relationships, environment, and sharing knowledge, has been demonstrated in the discussions of other defining attributes.[52] This awareness affirms the importance of context for WCC emphasised by the literature review.

MLU midwives' commitment to WCC was translated into intense focus on women. which helped them detect what women needed, despite not knowing them beforehand, and without over reliance on conversation. Their behaviours reflect what Kennedy et al. (2004) revealed in their narrative analysis of accounts midwifery participants gave of care given to women in labour. Kennedy et al. identified the quality of 'engaged presence', where midwives constructed impressions of women's labours through 'astute observations'. Although Kennedy

[52] The birthing environment has been discussed in relation to professionalism and autonomy for the first defining attribute. Relationships have been considered in discussing the third defining attribute.

et al. did not directly observe the labours from which the narratives were derived, they surmised that the impressions midwives formed came from combining clinical knowledge and experience with women's perspectives of their own situations, representing the creation of shared knowledge.

MLU midwives made themselves physically close and able to observe women's cues and reactions. Their presence reflected what Sosa et al. (2018) discussed in their study of one to one support in labour (2018). They suggested that it was midwives' proximity and interaction with women during labour that enabled them to be in tune with women's needs. They also considered reciprocal connections between midwives and women, where each contributed to optimal relationship building. The notion of reciprocity had been developed in an study by Hunter (2006) who created a model of different versions of midwife-women relationships, from 'balanced exchange', where there was give and take between both parties, to 'unsustainable exchange' where more was demanded of the midwife than they could give.

The reciprocal behaviours of MLU midwives, however, were less about mutual benefit. There was no indication that midwives consciously wanted anything from their exchanges with women. Instead, MLU midwives enacted reciprocity through spontaneous mimicry of women's movements and actions, resembling observations of early childhood behaviour discussed by Douglas (2007). Douglas described video recordings of interactions between newborn babies and their caregivers, which have become seminal to the fields of psychoanalytic theory and child psychology. Newborn babies imitating facial expressions and other gestures of their caregivers were considered examples of reciprocity. Douglas imagined togetherness, rhythm, and emergence of a 'responsive object' as qualities of reciprocity. Her contention that reciprocity of this nature applied to all relationships make it a fitting reference point for the midwifery practices observed. It is also likely that these midwifery behaviours signalled midwives empathising with women's situations. Moloney and Gair (2015) portrayed empathy as understanding and sharing another's feelings and putting oneself in another's shoes. In Barraza's and

Zak's (2009) study of empathetic acts towards strangers, positive correlations were shown between empathy, prosocial behaviours such as reciprocity, and oxytocin release. Empathising helped MLU midwives tune in to women's affective states, motivating them to respond effectively when needed.

In addition to focussing on women, enacting reciprocity and empathy, the findings of this study showed MLU midwives centring women, physically adapting themselves in ways that minimised disturbance, sometimes at the cost of discomfort to themselves. Healey et al. (2020) claimed that in the wider literature, details of this nature are not well developed and that midwifery care, particularly in the second stage of labour, has not been well documented. They published a systematic review of evidence supporting high quality intrapartum care in the second stage of labour. The review found that certain midwifery practices relating to women's birthing positions, pain relief, methods used in 'pushing ', and perineal care correlated with optimum outcomes. However, the review was not able to establish details of that care and support in labour due to the design of included studies, and what had been prioritised as worthy of investigation. For example, the review concluded that midwives assisted women to adopt positions of their choice, however, the behaviours they displayed in enacting this assistance, were not captured in the literature. In contrast, the findings of this research paint a picture of a range of individual focussed behaviours, practices, and actions, from adopting supported squatting positions with women, to holding hands and applying massage techniques in whatever position the women found comfort in. In making these behaviours visible, this study contributes to the limited knowledge of these finer details of midwifery led intrapartum care.

8.5.2 Decision making

Decision making has been explored in this chapter with reference to other defining attributes of midwifery led care. Midwifery decision making was portrayed as a

dynamic process of weighing up possible actions and intervening judiciously. It was also linked with professional autonomy, because through it, MLU midwives had the authority to arrive at decisions based on what they thought was important. Accepting women's autonomy in decision making could, however, be problematic for midwives when they did not agree with them. The findings of this study corroborate the literature review in acknowledging how relationships, midwifery autonomy and diverse knowledge (intuitive and rational) influenced midwifery decisions. The findings also showed MLU midwives adapting different principles of decision making, depending on the circumstances of a women's labour (Noseworthy et al., 2013). They took account of women's familial circumstances, and intentionally avoided paternalistic approaches which would have contradicted their women centred philosophy of care. Although they were versed in the narrative of informed choice and consent, the MLU midwives' actions showed commitment to building relationships with women so that negotiating care was acceptable to both parties. Thus, there was blurring of the theoretical lines between the models of decision making proposed by Noseworthy et al. (2013) in response to how labour was unfolding at any given time.

The findings contrast with what the literature review highlighted as midwives overriding women's decisions in situations that were acute and in need of either urgent or emergency referral. Rather than seeking compliance, or exerting coercion, the findings illustrated how MLU midwives negotiated with women even when their choices challenged their perceptions of safe care. This chapter has already uncovered MLU midwives' vulnerability when caring for women with evolving complications who decline treatment and proposed how this was a consequence of advocating for women. Such situations also demonstrate MLU midwives incorporating different principles of decision making into their practice, enacting both 'shared decision making' and exemplifying women as 'final decision makers'. This may be an important finding in understanding how decision making as a fluid and dynamic process in midwifery led care.

The findings of this study added to the literature review by acknowledging collective decision making as a dimension of midwifery led care. MLU midwives looked to midwifery colleagues for assistance and a second opinion about women's progress or possible deviations from normality. They consulted each other when their own energy levels were low, in both acute and non-acute situations. In their relatively isolated situations, they were invested in providing and receiving non-judgemental opinions about women's care from colleagues. Such findings mirror Sosa et al.'s (2018) ethnography where midwifery peer support in midwifery led settings was a balancing, energising factor for midwives. In the same way collective decision making was experienced as supporting and restorative to the MLU midwives of this study.

8.6 Conclusions of the research

8.6.1 A model for the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings

This thesis presents a comprehensive account of how the defining attributes of midwifery led care (MLC) were enacted in midwifery led intrapartum settings. It dealt with the multifaceted nature of midwifery led care and demonstrated how the practices and strategies used were interrelated, and influenced by other factors such as how they worked together locally as organisational collectives. The study demonstrated that the defining attributes were embedded features of midwifery led care, consisting of more than what the literature review revealed, with levels of complexity that came to light through the processes of the research. The themes and subthemes of the defining attributes, presented and critically discussed in the previous chapters, encompassed the practices and strategies midwife participants used in enacting the defining attributes of midwifery led intrapartum care. This comprehensive picture is summarised in Table 8.2 and 8.3 below, which takes account of influences of wider factors, such as the social model of care.

Defining attribute sub Themes	Enactment/expression midwifery practice	Wider/external influences on enactment
Leading care through expertise	Taking responsibility for organising/giving care/making decisions. Valuing experience and expertise in themselves and others, to make sound decisions. Valuing experience for the knowledge it brings.	Self-evident position. Acknowledged in regulatory/global standards of care/intrinsic to the role. Expertise as defence against external criticism. Expertise as selling point of service. Safe local organisational culture due to experience and expertise.
Advocating for women	Speaking up for women to family or professionals, being assertive. Prioritising women's decisions; not overriding their decisions in emergencies. Exercising discretion as street level bureaucrats.	Self-evident position. Acknowledged in regulatory/global standards of care/ intrinsic to the role. Need support of wider maternity team to honour women's challenging decisions in emergencies.
Problematic autonomy	Downgrading autonomy in midwifery led care settings. Lowering defences in MLU setting.	Self-evident position. Acknowledged in regulatory/global standards of care/ intrinsic to the role. Autonomy as a defence against hierarchical maternity systems. Proximity to OU influencing autonomy.
Knowing and understanding normality	Believing in women's capability and physiology. Calling on multifaceted knowledge. Acknowledging and using intuition.	Social model of childbirth.
Balancing action and no action	Applying deliberate conscious inactivity. Weighing up interventions and trading off. Not rescuing women from physiology. Negotiating with women in decision making. Complex decision making. Sustaining and valuing an local organisational culture.	Social model of childbirth. Safe local organisational culture.

Table 8-2 Midwifery enactment and expression of defining attributes of midwifery led care

Defining attribute sub Themes	Enactment/expression midwifery practice	Wider/external influences on enactment
Relationship	Circumventing absence of continuity models through collaboration, flexibility, being attuned to women's individuality, trust, presence, creating calm environments. Treating women like family. Being professional servants. Caring about birthing partners. Collaborating with them. Being emotionally connected with women Behaving with altruism.	Social model of care.
Communicating	Offering positive reassurance/ affirmation of normality, reframing with positive tone. Being mindful of women's sensitivity to negative talk. Facilitating understanding about events in labour. Valuing through relationship	Social model of care.
Being responsive	Physical closeness, reciprocity and mimicking, empathy. Intense focus on women, engaged presence. Prioritising women's comfort.	Social model of childbirth.
Making decisions about care	Making collective decisions with colleagues. Partnering with women in decision making. Negotiating with women in decision making.	Safe local organisational culture.

Table 8-3 Midwifery enactment and expression of defining attributes of midwifery led care (continued)

A simplified conceptual model has been constructed, consisting of a central component of enactment of midwifery led intrapartum care, the analytical frame

clarified in Chapter 4 (Thomas, 2016)[53] (Figure 8.1). The central component defines themes and subthemes to the left of the model. In reality, expressions of the midwife participants' practice are associated with more than one theme. for example, decision making is a function of being a lead professional, and making decisions about interventions in labour. These interrelationships are apparent in Tables 8.2 and 8.3. Inductive themes and sub themes denote factors which influence midwifery care. The inclusion of these secondary themes makes the model comprehensive, in that it represents the entirety of midwifery led intrapartum care. In doing so, it demonstrates that findings of this qualitative case study have addressed the research aims and research question.

[53] The analytical frame was identified in Chapter 4 as being the enactment of midwifery led care in midwifery led intrapartum settings, which combined with the subject, i.e. the midwifery led intrapartum care unit, consisted of the 'case' in this case study.

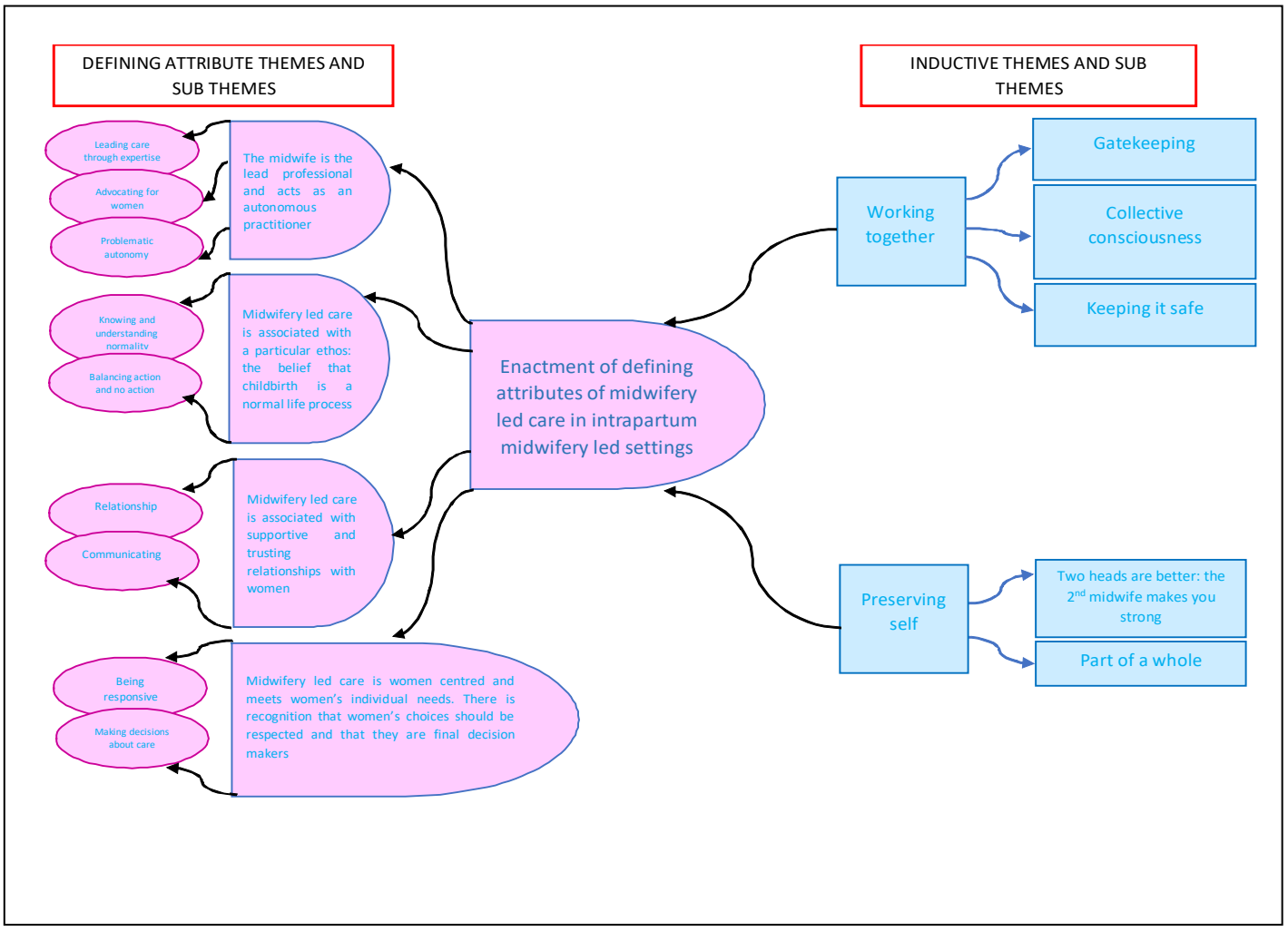

Figure 8-1 Conceptual model of the enactment of the defining attributes of midwifery led care with context of midwifery led intrapartum care provided by inductive themes and sub themes

8.7 Strengths of the study

The current study set out to determine how the defining attributes of midwifery led care are enacted in midwifery led intrapartum settings by conduction a multiple case study. The findings of the study were critically analysed in this chapter and demonstrated that the defining attributes represent an authentic picture of midwifery practice in the 2 selected cases of midwifery led intrapartum care. The strengths of this study arise from the research design and the methodologically sound processes used in addressing the research aim and research question. The study is the first to incorporate concept analysis, qualitative case study, and framework analysis in order to investigate and explore how a theoretical understanding of midwifery led care translates in to midwifery practices. Concept analysis established the context of midwifery led care through its surrogate case, antecedents, and consequences. It then identified a model case, and a related case for the model case to be compared against. The literature review established meanings of the defining attributes themes in the wider literature. The case study approach was an ideal mechanism for an in depth exploration of the cases, using several different methods of data collection ensured triangulation, and allowed for other influences on the enactment of midwifery led care to be revealed. Framework analysis methods, and use of NVIVO 11 &12 enabled decisions made in analysing and interpreting data to be transparent, with emergent codes and themes traceable back to the raw data.

8.8 What the study adds to existing knowledge

The findings of this qualitative multiple case study build on the understanding of the enactment of defining attributes of midwifery led care established in the literature review. The study found that distance from the 'host' maternity service and obstetric unit strengthened MLU midwives' opportunities to act autonomously and preserved the collective ethos that normal physiological birth was achievable,

and the norm. This led to considering the discretion MLU midwives were able to apply to their practice, and their parallels with street level bureaucrats. The study also enhanced the picture of autonomy and leadership by revealing the premium placed on expertise and experience in themselves and colleagues, and how this served their need to demonstrate their safety, and so protect their 'territory'. What is unique for this study, with respect to autonomy, was the negation of the need for autonomy when immersed in the MLU environments. In their familiar settings the midwives accepted relinquishing autonomy to women. Autonomy could then be revived when dealing with forces external to the MLUs. Although this finding is broadly consistent with Irving's research into UK independent midwives, it has not been recognised as a feature of NHS based midwifery led care.

The current study also contributes to understanding how midwives negotiate the difficulties of caring for women whose choices are viewed as problematic and/or unsafe, and how midwives work through their desire to override women's decision. Though this can be seen as further validation of women as final decision makers, in increasingly risk averse maternity services (Walsh, 2003; Miller et al., 2016) it is important to highlight midwives' needs for support from the wider maternity team.

'Normal birth' appears to be as contentious as it was in 2017 when Dahlen composed her response to calls for the downgrading of 'normal' vaginal birth as a desired outcome of pregnancy. The added clamour for the removal of the descriptor 'normal' from midwifery talk and discussions about childbirth came recently from the Health and Social Care Committee hearing of the progress of the Independent Maternity Review at the Shrewsbury and Telford Hospital NHS Trust (Parliamentlive.TV, 2020). The focus of the review is on reported cases of maternal and neonatal morbidity and mortality between 2000 and 2019. Like the previous review into maternal and neonatal deaths at Furness General Hospital (Kirkup; 2015) preliminary findings of 250 cases present a sobering picture of poor care with respect to, for example, compassion and kindness, risk assessment for place of birth, and escalation of concerns. These and other themes were implicated in

adverse outcomes. Belief in women's capacity to give birth was uncontroversial for MLU midwives, who identified with the social model of birth discussed earlier in the chapter. The findings suggest, however, that alongside commitment to normal birth MLUs were preoccupied with safety, and strove to demonstrate that they were competent and safe practitioners to their wider maternity services colleagues. The theme of safety was identified through open coding of data generated by this study and casts an interesting light on the safety culture of the MLUs. As well as being reactive to their perceptions of how OU colleagues regarded them, there was satisfaction in their skills for managing obstetric emergencies and recognising labour dystocia; they valued being skilled in dealing with higher risk situations. The broad implication in the present research, therefore, is that MLU midwives were pragmatic in the knowledge they relied on. Their organisational culture, influenced by the social model of childbirth, also accommodated high tech maternity care. This will be an important point to emphasise in present and future debates about normal birth.

This study provides a basis for understanding how intrapartum care in an unknown midwife model can result in midwives establishing relationships with women. The study revealed purposive strategies MLU midwives used to enhance connections which included treating women like family members and looking after birthing partners. Collectively, these findings may provide clues to how women benefit from using the MLU services not associated with continuity of care.

8.9 Limitations of the study

Having presented the strengths of the study, this section looks at the extent to which factors outside the control of the researcher have acted as limitations. Chapter 5 of this thesis presented the design and methods planned for the study. It also discussed the stages taken to address the fact that fewer than the anticipated number of women were recruited during the earlier stages of the study for Case 1.

Substantive amendments to the protocol, which have also been discussed in Chapter 5, addressed this problem, however, conditions embedded in the Ethics Committee's approval determined that women were to be give informed consent to participate in the study prior to entering the latent or early stage of labour. Thus, consent was to be gained potentially days in advance of labour, and verified at the time of labour admission. Implications of this strategy were that the researcher was unable to approach women who presented with possible labour, which went on to become established in the same episode of care.

The Ethics Committee also mandated that the researcher approached women about the study and obtained their consent to participate rather than the midwives providing care, as it was felt that coercion would be less likely than if the midwives took on this role. It is of note that there is a range of ethical opinion concerning the matter of potential for coercion in childbirth research. In Sosa's (2017) ethnographic study of 'one to one' midwifery care, it was the midwives who were required to recruit women onto the study, whereas for Rocca-Ihenacho's (2016) research, as participant observer, she conducted recruitment herself.

A limitation of this study, therefore, was that due to the length of time involved in determining and agreeing substantive amendments, 1 observation of labour took place at Case 1. For case 2, the discussion in Chapter 5 has recorded midwives' opinions that the drop in birth rate at the FMU followed the opening of an additional intrapartum birthing centre, an AMU. This acted as a significant factor in limiting potential observations to 2. The depth and consistency of interview data alongside that from the observations, however, provided an abundance of material suitable for addressing the research question and developing a model of midwifery led intrapartum practice with respect to its defining attributes.

8.10 Recommendations for practice

Maternity service leaders and managers should ensure midwives working in MLUs have structured, supporting mechanisms to escalate concerns when providing care in equivocal situations with respect to safety, for example women declining transfer to an OU when a deviation from normal occurs. This study suggests that midwives prioritise the principle of women and final decision makers, yet also want to feel safe.

Maternity service leaders and managers should take practical measurable steps to improve communication and relationships between the MLU and OU, or other parts of the service. Repeated reports of poor outcomes in maternity or health services draw attention to poor communication leading to poor maternal and perinatal outcomes (Francis, 2013; Kirkup, 2015). In addition, poor communication and relationships, a recent report from the King's Fund 'The courage of compassion' (2020) identified key areas that needed actions with respect to core work needs. They included effectively functioning teams and nurturing cultures. These areas related directly to midwives (and nurses) feeling connected to, cared for and respected by colleagues.

8.11 Recommendations for research

The study prioritised perspectives of midwives in answering the research question. It has shown what midwives value and strive to achieve in developing brief relationships with women. Research is needed to understand how women experience the actions midwives mobilise when enacting midwifery led care. This could be achieved through interviewing women who have given birth in similar settings.

The study reported on findings derived through open coding (Chapter 7) organised around 2 themes: preserving self and working together. Although these themes

were not directly used to answer the research question, they provide interesting and valuable contextual information which could be explored further.

8.12 Recommendations for education

This research has resulted in the development of a model of the enactment of midwifery led care in midwifery led intrapartum settings. This model can be developed into educational materials to introduce pre-registration midwifery students to midwifery led intrapartum care. The model encompasses behavioural skills, philosophy of care, and organisational factors that facilitate the enactment of midwifery led care. Educational materials can also be developed to orientate midwives rotating to MLUs, and to inform women of the details of care.

8.13 Final summary

This is the first study to apply concept analysis to midwifery led care, and explore how its defining attributes are enacted in midwifery led intrapartum care. Choosing two cases to conduct the study added to the depth of the findings. Combining several data collection methods addressed the need for triangulation. The study supported what the concept analysis indicated as being the essential components, or defining attributes of midwifery led care; MLU midwives commented on the model case (developed in the concept analysis process) as being a 'typical freestanding model of care' 'not idealised' and 'not unattainable' (Chapter 7).

The findings for this thesis provide comprehensive analysis of the techniques and strategies MLU midwives used in enacting midwifery led care, these techniques and strategies were expressed through the sub themes of the research. The findings also demonstrate that the local organisational culture within the MLUs is supportive and protective. Midwives collaborate with their MLU colleagues and value support from the wider maternity team, although there were often tensions between the two settings. The findings of this thesis will be shared with the participating MLUs,

the service user groups who provided feedback on the study during the design stage. The intention is for findings to be published in peer review journals.

8.14 Dissemination of research study findings

Work has already taken place to disseminate findings of this research study, in the form of the following Poster presentations

Caine, D; Crozier, K; Moore, J (2016) An exploration of the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings *University of East Anglia Post Graduate Student Conference February 2016*

Caine, D; Crozier, K; Moore, J (2019) An exploration of the enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings *University of Central Lancashire 14th International Normal Labour and Birth Conference June 2019*

In addition, findings have been presented to the Audit Committee meeting of Case 2. Arrangements for discussing the case study with participant midwives, service users and midwifery/ Trust managers is due to take place. The researcher will also present to a local maternity research group.

Glossary

Alongside Midwifery Unit (AMU)	The midwifery led unit is situated on the same site as an obstetric unit.
Augmentation	The speeding up of labour by the use of drugs.
Amniotic fluid	Sometimes called liquor, the fluid that surrounds the fetus in the uterus.
Artificial Rupture of Membranes (ARM)	Making a hole in the fetal membranes using an instrument, usually an amnihook.
Caesarean section	Delivery of an infant through an incision in the abdominal and uterine walls.
Dilatation/dilation	The process of the cervix opening in labour.
Doppler	A machine that detects the heartbeat by ultrasound.
Entonox/ Gas and Air	A mixture of oxygen and nitrous oxide, inhaled through a mask or mouthpiece.

Epidural	An injection of local anaesthetic into the lower back.
Episiotomy	A cut made in a woman's perineum allow the baby to be born more quickly.
Fetus	The baby from about 12 weeks until birth
First stage of labour	The time from the beginning of labour until the cervix is fully dilated.
Forceps	A pair of hollow blades which are placed either side of the baby's head to assist with the birth.
Freestanding Midwifery Unit (FMU)	The midwifery unit is situated separately from the OU it is linked with.
Gestation	Length of pregnancy.
Haemorrhoids/ Piles	Blood vessels protruding inside or around the anus.
Haemorrhage	Sudden and severe bleeding
Induction	Artificially starting labour .

Latent phase	Onset of labour prior to established labour.
Meconium	The bowel contents of a fetus/baby at birth.
Membranes sweep	A method of inducing labour. Consists of a vaginal examination and attempt to stretch the cervix.
Midwifery led unit (MLU)	A maternity unit where midwives are the lead professionals.
Multiparous	Having given birth to a baby before.
Obstetric Unit (OU)	A maternity unit where obstetricians are the lead professionals.
Occipito Posterior (OP)	The fetus's occiput (a plate of bone at the back of the head) is towards the woman's back.
Oxytocin	The hormone secreted by women when they are in labour which stimulates labour contractions.
Perineum	The area of skin and musculature between a woman's vagina and anus.

Pethidine	A opioid used for pain relief in labour.
Primiparous	Being pregnant for the first time
Second stage of labour	The time from full dilation of the cervix to the birth of the baby.
Skin to skin	Contact between baby and care-giver where direct contact with skin is made.
Third stage	Period between birth of baby to delivery of placenta and membranes and control of bleeding.
Umbilicus/ umbilical cord	The thick cord of intertwining blood vessels that links baby and placenta, and carries oxygen and nourishment to the baby.
Ventouse	a method of vacuum extraction used in assisted delivery

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Appendices

A p p e nd i x 1 Search results for concept a n a lysis

Attributes of midwifery led care identified	Study methodology (if applicable)	Limitations of study
Women centred care. Continuity of care. Childbirth seen as physiological process. Minimal intervention; Lack of medical supervision	n/a	This is a short commentary explicitly supporting of one side of a motion. Only 4 papers referenced.
Philosophy of care encompasses Swanson' s processes of caring: Knowing (expanded using Caper); Being with; Doing for; Enabling; Maintaining belief.	Case study of a midwife-led unit	This is a case study based on one woman' s experience of maternity care used to draw conclusions about how theories of caring and knowing relate to midwife led care
Midwives work in partnership with women; Lead professional in assessing needs and care planning;	Literature review of maternity care policies in Ireland	n/a

	Journal, Title, Author/s (Year of publication)	Description of paper
	Controversies in Obstetric Anaesthesia ` Epidural analgesia is not compatible with midwifery led care'	Proposal of a motion on the compatibility of epidural analgesia with midwifery led care Intrapartum care
	RCM Midwives ` Examining the extent to which Swanson' s theory of caring and Carper' s ways of knowing can be identified in the process of midwife-led care' A n d e r s o n , G	Case study used to examine the theory of knowledge and of caring and application to midwifery led care in a midwifery led setting. The case uses the subject of one woman experience and outcomes of maternity care.
	Midwifery ` Childbirth policies and practices in Ireland and the journey towards midwifery – led care' Devane D; Murphy-Lawless J;	Discussion on policies and practice in Ireland and the move towards midwifery-led care

Report of outcomes of the first five years of the first midwife-led birth centre (MLBC) in Italy, an alongside centre. Exclusions were stated as being maternal diseases, complicated obstetric history, height < 150 cm, maternal age > 45, multiple pregnancy 1438 women admitted in the period of interest.	Women are able to book for care directly with a midwife Absence of routine attendance of medical staff Orientation towards normal birth	Data prospectively collected to analyse first 5 years' experience of the midwifery led birth centre	Data of outcomes for MLBC provided but lack of comparison with outcomes from hospital maternity unit
Cochrane systematic review comparing midwife led models of care with other models 11 trials assessed including 12276 women. Studies included where women randomised into either arm of trial with low and mixed risk of complications.	Midwives work in partnership with women; Continuity of care offered Belief in normality and ability of women to experience birth with minimal intervention. Caseload midwifery offers greater continuity and more in tune with midwife led care than team midwifery	Systematic review	Limitations identified by authors with respect to varying robustness of randomisation methods of included trials. Varying models of midwife
An assessment of mother' s satisfaction with caseload midwifery, taking extent of continuity into account, and linking findings with clinical outcomes data. 115 women responded, out of a possible 174 giving birth in study period (July 2004 – April 2005). 97 of these provided identified data (not anonymous). Australian study.	Continuity of care; Supportive relationships between women and midwives; Maternal satisfaction with respect to selected variables; Access to quality information;	Postal survey/self-completion questionnaires. Survey data then linked to clinical outcomes data	Limitation identified by authors is the lack of a comparison study
Exploration of Chinese women' s and healthcare professionals' views about midwife-led care in China. Concentrates on intrapartum midwife led care in the first midwife led birth unit to facilitate normal birth and enhance midwifery practice.	Midwife led care associated with: A homelike environment Minimal intervention Women centred care	Qualitative study using semi structured interviews, questionnaires and cross comparison with hospital data	Limitations identified by the authors: interventions such as episiotomy and augmentation of labour was widely used affecting generalisability of

Arch Gynecol Obstet	
Outcomes of the first midwife-led birth centre in Italy: 5 years' experience	
Morano S; Cerutti F; Mistrangelo E; Pastorino D; Benussi M; Costatini S;	
The Cochrane Collaboration	
' Midwife-led versus other models of care for childbearing women'	
Hatem M; Sandall J; Devane	
Midwifery	
' Mothers' views of caseload midwifery and the value of continuity of care at an Australian regional hospital'	
W i l l i a m s	
Midwifery	
' Views of Chinese women and health professionals about midwife-led care in China'	
Cheung NF; Mander R; Wang X; Fu W; Zhou H; Zhang L (2011)	

			to satisfaction with care and management
Investigation into pregnant women' s fear of childbirth looking at midwife and obstetric led care in Belgium and The Netherlands and comparing maternity care models	Midwife led care associated with: Lower intervention rates Specific ideology of birth as a normal physiological process	Questionnaire distributed in antenatal period; data subjected to multiple regression analysis	Limitations identified by the authors: lack of information about non-response and low response. Despite cultural and political similarities between the 2 countries
Exploration of midwifery discourse of the art of midwifery, to investigates what facilitates quality outcomes and generate a theoretical framework for practice	Midwifery care (in high and low risk settings) associated with: Presence Guardianship Intuition Confidence and courage	Literature review. Concepts associated with the art of midwifery analysed and synthesised from the literature	Limitations not considered by author; method of literature search and literature terms explicit as is description of literature used to arrive at
Comparison of midwifery led unit (MLU) and consultant led (CLU) of low risk healthy women in the Republic of Ireland. Seven key outcomes examined: caesarean birth, induction, episiotomy, instrumental birth, Apgar score, post-partum haemorrhage, breastfeeding initiation, Continuous electronic fetal monitoring (CEFM),	Midwifery led care is less prescriptive; Principle of childbirth being normal and physiological life changing event; Midwife is the lead professional; Continuity of care	Unblinded pragmatic randomised trial. Data analysis by intention to treat	Limitations identified by authors: lack of blinding of participants and carers resulting in potential unavoidable bias for both randomised groups
Report of the history, practice, and outcomes of Marin County' s maternity service (US)	Midwifery care is associated with reduction in overused practices such as caesarean birth,	n/a	n/a

Midwifery ‘ Pregnant women’ s fear of childbirth in midwife and obstetric look care in Belgium and the Netherlands: test of the medicalization hypothesis Christiaens W; Van de Velde S; Bracke P (2011)
MIDIRS digest ‘ The art of midwifery practice: a discourse analysis MacLellan J (2011)
BMC Pregnancy and Childbirth ‘ Comparison of midwife-led and consultant – led care of healthy women at low risk of childbirth complications in the Republic of Ireland: a randomised trial Begley C; Devane D; Clarke M; McCann C; Hughes P; Reilly M; Maguire R et al
Journal of Midwifery and Women’ s Health

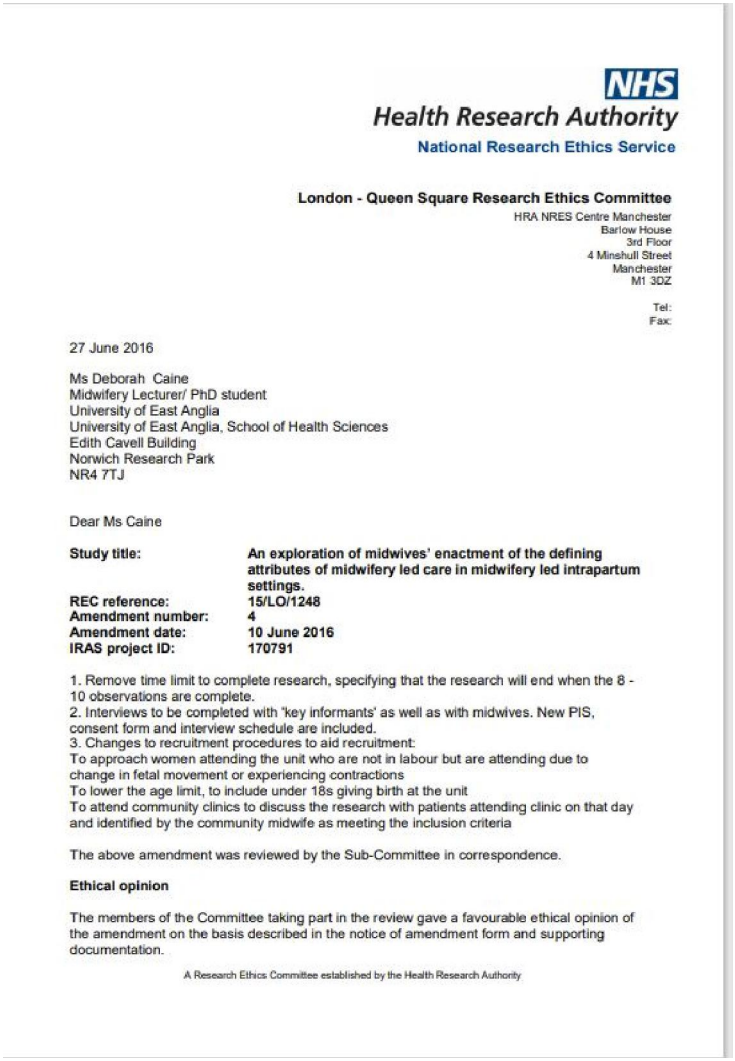
Comparison of midwife led, and doctor led maternity care by analysing existing systematic reviews. This work informed the UK Commission on the future of UK Nursing and Midwifery. 3 reviews included.	Midwifery-led care associated with: Fewer procedures in labour (fewer interventions) Greater maternal satisfaction A continuing relationship with women	Systematic review of reviews (3 reviews included)	Limitations identified by authors relate to included reviews having different objectives to meta review, e.g. comparing physician care with nurse midwife and midwife care. In
Commentary on value of midwife led antenatal care option for low risk women	Continuity of care; Provision of choice; Development of trusting relationships with women and partners	n/a	n/a
Metasynthesis of qualitative research relating to midwife led care in intrapartum care settings	Greater agency for women and midwives Autonomous care by a midwife encompassing emotional presence, empathetic care	Metasynthesis (11 articles included)	Limitations identified by authors: the potential for different interpretations of findings from other researchers. The lack of population generalizability characteristic of
Review of literature to assess safety of non- medically led primary maternity care models in Australia Intrapartum care settings	Midwife led care associated with: Fewer interventions Greater likelihood of normal birth	Literature review (22 nonrandomised international studies included). Outcome measures perinatal mortality and morbidity,	Authors discussed as limitations debates around the quality of evidence available

` Expanding access to midwifery care: using one practice' s success to create community change'	
Journal of Advanced Nursing	
` Comparing midwife-led and doctor-led maternity care: a systematic review of reviews'	
Sutcliffe K; Caird J; Kavanagh J; Rees R; Oliver K; Dickson K	
World of Irish Nursing and Midwifery	
` Antenatal options: developing midwife-led services in Ireland	
Murphy A	
Qualitative Health Research	
` A metasynthesis of midwife-led care'	
W a l s h D ;	
Australian Health Review	
` Safety of non-medically led primary maternity care models: a critical review of the	

		intrapartum referral and transfer rates	low risk women receiving different models of care
SEARCHED	PUBLICATIONS		
Exploration of epistemological underpinnings of midwife led care by research into how midwives use their knowledge to promote normal birth in a midwife led environment	Midwifery knowledge is ordered around categories of understanding, observing, knowledge from experience and judgement	Qualitative critique of semi structured interviews with nine midwives working in a midwifery led environment	Limitations not considered by author but relate to the issue of non generalisability of these study findings to other settings
Department of Health policy document describing a proposed national framework for the maternity services that incorporates choice, access, and continuity	Midwifery led care is deemed appropriate for some women with midwives being coordinators of care for vulnerable and higher risk women. The guiding principle of the service is continuity	n/a	n/a
Proposal for the midwifery contribution to the maternity services in 2020	Midwifery led care is associated with: Social model of maternity care i.e., women centred vs. organisation centred Fewer hospital admissions in the antenatal period Fewer intervention during birth	n/a	n/a
Report of the Birthplace in England cohort study	Midwifery led care in non-Obstetric unit settings for ' low risk' women is associated with fewer obstetric interventions such as epidural or spinal, episiotomy. This is in comparison with ' low risk' women cared for in an obstetric unit. Midwifery led care in a non-obstetric unit for low risk women is also associated with higher rates of normal birth	A prospective cohort study comparing the safety of planned place of birth at the start of care in labour for women judged ' low risk' at the start of labour.	

Meredith J (2012)
HAND
Evidence based midwifery ‘ The epistemological foundation of midwife-led care that facilitates normal birth’
Department of Health (2007) ‘ Maternity
Department of Health Midwifery 2020: Department Delivering expectations CNOs of England, Northern Ireland, Scotland, and Wales (2010)
National Perinatal and Epidemiology Unit ‘ Birthplace in England national prospective cohort study’ Hollowell J; Puddicombe

Appendix 2 Ethics committee substantive review favourable decision



NHS
Health Research Authority
National Research Ethics Service

London - Queen Square Research Ethics Committee
HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel:
Fax:

27 June 2016

Ms Deborah Caine
Midwifery Lecturer/ PhD student
University of East Anglia
University of East Anglia, School of Health Sciences
Edith Cavell Building
Norwich Research Park
NR4 7TJ

Dear Ms Caine

Study title:	**An exploration of midwives' enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings.**
REC reference:	**15/LO/1248**
Amendment number:	**4**
Amendment date:	**10 June 2016**
IRAS project ID:	**170791**

1. Remove time limit to complete research, specifying that the research will end when the 8 - 10 observations are complete.
2. Interviews to be completed with 'key informants' as well as with midwives. New PIS, consent form and interview schedule are included.
3. Changes to recruitment procedures to aid recruitment:
To approach women attending the unit who are not in labour but are attending due to change in fetal movement or experiencing contractions
To lower the age limit, to include under 18s giving birth at the unit
To attend community clinics to discuss the research with patients attending clinic on that day and identified by the community midwife as meeting the inclusion criteria

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

A Research Ethics Committee established by the Health Research Authority

The sub-committee had the following queries:

- Please advise whether you will include under 16s
- Please advise whether you will be lone working at any point when out in the community centres
- Please provide age appropriate information sheets and consent forms for under 18 year olds.

You provided information sheets and responded by email: *'my intent is to include 16 and 17 year olds ('young people') only. There will not be any lone worker issues. 16 to 17 year old people are considered capable of giving consent independently of their parents provided information is given and it is given voluntarily (as with adults)'*

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Indicative interview guide for key informants]	1	01 June 2016
Notice of Substantial Amendment (non-CTIMP)	4	10 June 2016
Other [Response to committee query]		21 June 2016
Participant consent form [Midwives (key informants)]	1	01 June 2016
Participant consent form [Young women]	1	01 June 2016
Participant information sheet (PIS) [Midwives (key informants)]	1	01 June 2016
Participant information sheet (PIS) [Young women]	1	01 June 2016
Research protocol or project proposal	4	01 June 2016

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/LO/1248:	**Please quote this number on all correspondence**

Yours sincerely

A Research Ethics Committee established by the Health Research Authority

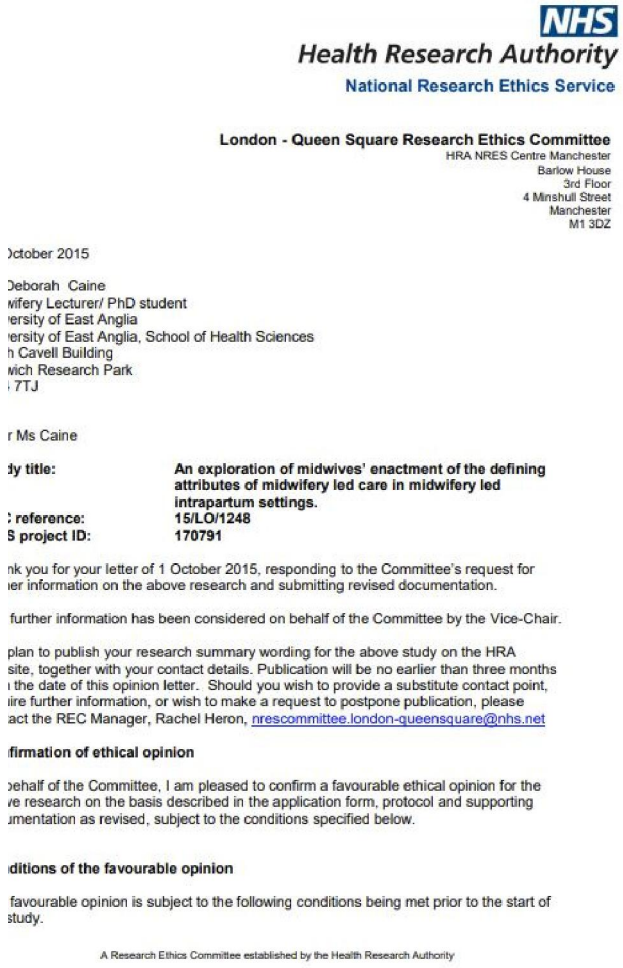
ed on behalf of
amonn Walsh
r

ail: nrescommittee.london-queensquare@nhs.net

sures: *List of names and professions of members who took part in the review*

to: *Dr Sally Burtles, Barts Health NHS Trust*
Ms Yvonne Kirkham

Append ix 3 Ethics Committee favourable opinion October 2015



NHS
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)ctober 2015

Deborah Caine
vifery Lecturer/ PhD student
'ersity of East Anglia
'ersity of East Anglia, School of Health Sciences
h Cavell Building
vich Research Park
: 7TJ

r Ms Caine

dy title: **An exploration of midwives' enactment of the defining attributes of midwifery led care in midwifery led intrapartum settings.**
: reference: **15/LO/1248**
S project ID: **170791**

nk you for your letter of 1 October 2015, responding to the Committee's request for ıer information on the above research and submitting revised documentation.

further information has been considered on behalf of the Committee by the Vice-Chair.

plan to publish your research summary wording for the above study on the HRA site, together with your contact details. Publication will be no earlier than three months ı the date of this opinion letter. Should you wish to provide a substitute contact point, iire further information, or wish to make a request to postpone publication, please act the REC Manager, Rachel Heron, nrescommittee.london-queensquare@nhs.net

ffirmation of ethical opinion

)ehalf of the Committee, I am pleased to confirm a favourable ethical opinion for the ve research on the basis described in the application form, protocol and supporting ımentation as revised, subject to the conditions specified below.

ıditions of the favourable opinion

favourable opinion is subject to the following conditions being met prior to the start of study.

A Research Ethics Committee established by the Health Research Authority

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Poster]	2	18 June 2015
Copies of advertisement materials for research participants [Leaflet]	2	18 June 2015
Covering letter on headed paper		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UAE Indemnity]		26 June 2015
Interview schedules or topic guides for participants [Indicative Observation Guide]	2	
Interview schedules or topic guides for participants [Indicative]	2	18 June 2015
IRAS Checklist XML [Checklist_01102015]		01 October 2015
Other [Gantt chart research cycle]		
Other [Translation Letter]		
Other [PIS women]	version 5	30 September 2015
Other [Consent for women]	version 4	30 September 2015
Other [RCM statement on action in emergency version 1]	version 1	25 September 2015
Other [Research summary A6-1]	version 2	30 September 2015
Participant consent form [Midwives]	3	18 June 2015
Participant consent form [Women]	3	18 June 2015
Participant consent form	version 5	30 September 2015
Participant information sheet (PIS) [Midwives]	02	25 June 2015
Participant information sheet (PIS) [Women]	4	25 June 2015
Participant information sheet (PIS) [PIS midwives version 3]	version 3	30 September 2015
REC Application Form [REC_Form_02072015]	4.0.0	02 July 2015
Research protocol or project proposal	version 3	30 September 2015
Summary CV for Chief Investigator (CI) [Deborah Caine]		02 June 2015
Summary CV for supervisor (student research) [Kenda Crozier]		
Summary CV for supervisor (student research) [Jenny Moore]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

orting requirements

attached document *"After ethical review – guidance for researchers"* gives detailed ance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

HRA website also provides guidance on these topics, which is updated in the light of nges in reporting requirements or procedures.

r Feedback

Health Research Authority is continually striving to provide a high quality service to all licants and sponsors. You are invited to give your view of the service you have received the application procedure. If you wish to make your views known please use the lback form available on the HRA website: http://www.hra.nhs.uk/about-the-governance/quality-assurance/

Training

are pleased to welcome researchers and R&D staff at our training days – see details at //www.hra.nhs.uk/hra-training/

.O/1248	**Please quote this number on all correspondence**

the Committee's best wishes for the success of this project.

rs sincerely

ed on behalf of
Eamonn Walsh
-Chair

il: nrescommittee.london-queensquare@nhs.net

losures: "After ethical review – guidance for researchers" *[SL-AR2]*

y to: *Ms Yvonne Kirkham*
Dr Sally Burtles, Barts and the London NHS Trust

sfield Street, London W1G 9NH T 0207 312 3535 F 0207 3536 E info@rcm.org.uk Website www.rcm.org.uk

oyal College of
dwives

ieptember 2015

Deborah

cting in an emergency as a researcher

CM does not have a position statement relating to the responsibilities of a midwife undertaking research. As the professional body we would advise that in the case of an gency situation during labour, the researcher is required by her registration with the to abide by The Code which states in relation to acting in an emergency that the trant must:

15. Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

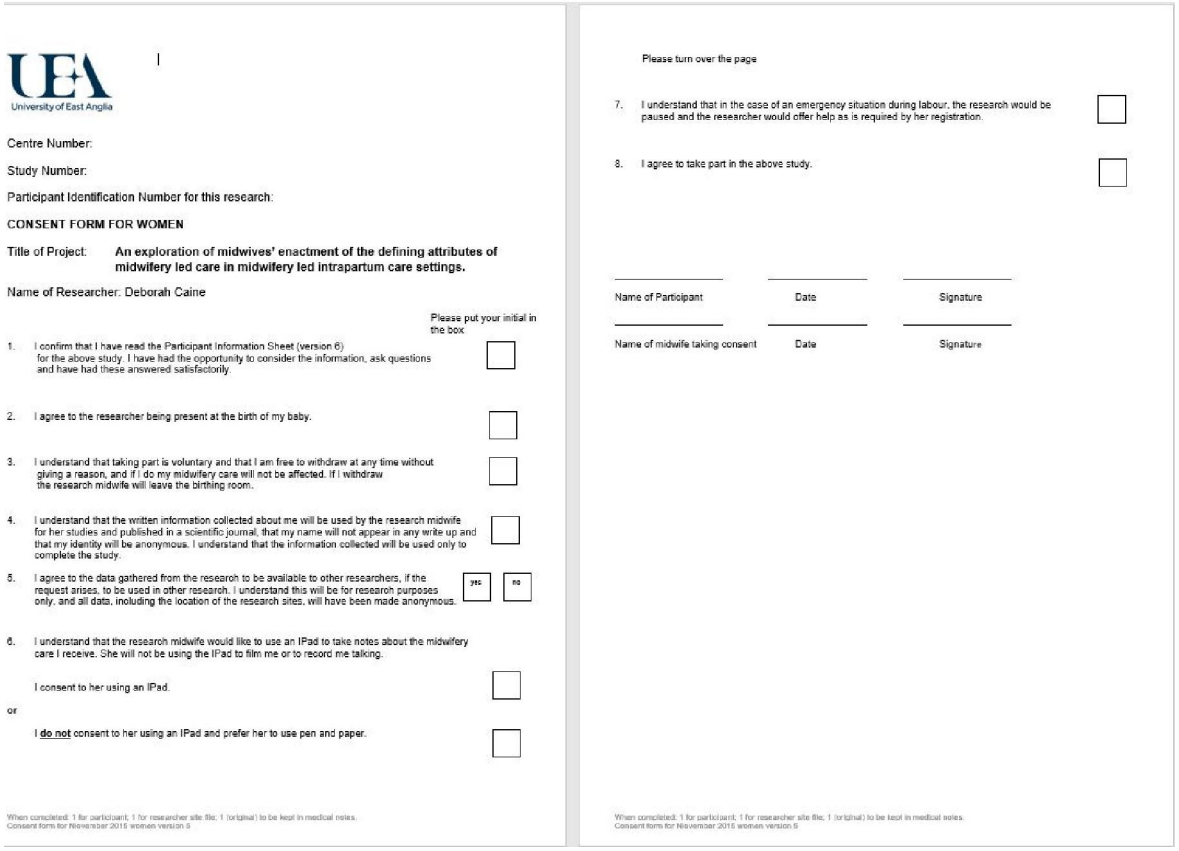
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly, and

15.3 take account of your own safety, the safety of others and the availability of other options for providing care.

have any further queries, please let me know.

egards
el

el Lloyd
of Education and Learning



University of East Anglia

Centre Number:

Study Number:

Participant Identification Number for this research:

CONSENT FORM FOR WOMEN

Title of Project: **An exploration of midwives' enactment of the defining attributes of midwifery led care in midwifery led intrapartum care settings.**

Name of Researcher: Deborah Caine

Please put your initial in the box

1. I confirm that I have read the Participant Information Sheet (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I agree to the researcher being present at the birth of my baby. ☐
3. I understand that taking part is voluntary and that I am free to withdraw at any time without giving a reason, and if I do my midwifery care will not be affected. If I withdraw the research midwife will leave the birthing room. ☐
4. I understand that the written information collected about me will be used by the research midwife for her studies and published in a scientific journal, that my name will not appear in any write up and that my identity will be anonymous. I understand that the information collected will be used only to complete the study. ☐
5. I agree to the data gathered from the research to be available to other researchers, if the request arises, to be used in other research. I understand this will be for research purposes only, and all data, including the location of the research sites, will have been made anonymous. yes ☐ no ☐
6. I understand that the research midwife would like to use an IPad to take notes about the midwifery care I receive. She will not be using the IPad to film me or to record me talking.

   I consent to her using an IPad. ☐

   or

   I **do not** consent to her using an IPad and prefer her to use pen and paper. ☐

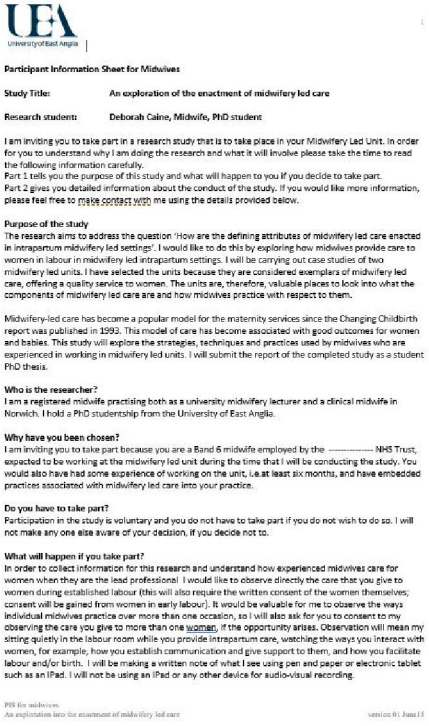
When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.
Consent form for November 2015 women version 6

Please turn over the page

7. I understand that in the case of an emergency situation during labour, the research would be paused and the researcher would offer help as is required by her registration. ☐
8. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of midwife taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.
Consent form for November 2015 women version 6



University of East Anglia

Participant Information Sheet for Midwives

Study Title: **An exploration of the enactment of midwifery led care**

Research student: **Deborah Caine, Midwife, PhD student**

I am inviting you to take part in a research study that is to take place in your Midwifery Led Unit. In order for you to understand why I am doing the research and what it will involve please take the time to read the following information carefully.
Part 1 tells you the purpose of this study and what will happen to you if you decide to take part.
Part 2 gives you detailed information about the conduct of the study. If you would like more information, please feel free to make contact with me using the details provided below.

Purpose of the study
The research aims to address the question 'How are the defining attributes of midwifery led care enacted in intrapartum midwifery led settings'. I would like to do this by exploring how midwives provide care to women in labour in midwifery led intrapartum settings. I will be carrying out case studies of two midwifery led units. I have selected the units because they are considered exemplars of midwifery led care, offering a quality service to women. The units are, therefore, valuable places to look into what the components of midwifery led care are and how midwives practice with respect to them.

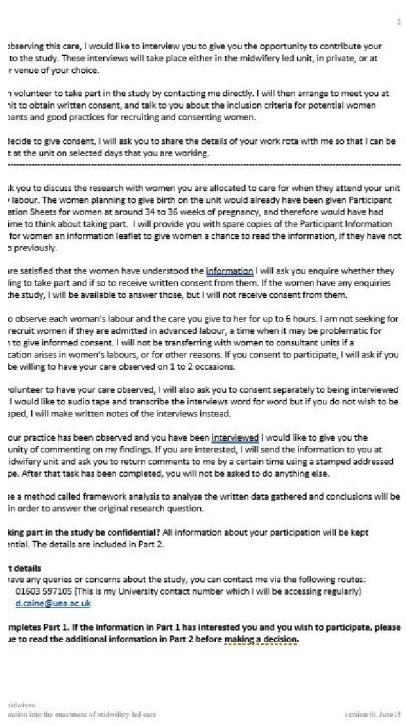
Midwifery-led care has become a popular model for the maternity services since the Changing Childbirth report was published in 1993. This model of care has become associated with good outcomes for women and babies. This study will explore the strategies, techniques and practices used by midwives who are experienced in working in midwifery led units. I will submit the report of the completed study as a student PhD thesis.

Who is the researcher?
I am a registered midwife practising both as a university midwifery lecturer and a clinical midwife in Norwich. I hold a PhD studentship from the University of East Anglia.

Why have you been chosen?
I am inviting you to take part because you are a Band 6 midwife employed by the ---------- NHS Trust, expected to be working at the midwifery led unit during the time that I will be conducting the study. You would also have had some experience of working on the unit, i.e.at least six months, and have embedded practices associated with midwifery led care into your practice.

Do you have to take part?
Participation in the study is voluntary and you do not have to take part if you do not wish to do so. I will not make any one else aware of your decision, if you decide not to.

What will happen if you take part?
In order to collect information for this research and understand how experienced midwives care for women when they are the lead professional I would like to observe directly the care that you give to women during established labour (this will also require the written consent of the women themselves; consent will be gained from women in early labour). It would be valuable for me to observe the ways individual midwives practice over more than one occasion, so I will also ask for you to consent to my observing the care you give to more than one women, if the opportunity arises. Observation will mean my sitting quietly in the labour room while you provide intrapartum care, watching the ways you interact with women, for example, how you establish communication and give support to them, and how you facilitate labour and/or birth. I will be making a written note of what I see using pen and paper or electronic tablet such as an IPad. I will not be using an IPad or any other device for audio-visual recording.



observing this care, I would like to interview you to give you the opportunity to contribute your to the study. These interviews will take place either in the midwifery led unit, in private, or at r venue of your choice.

n volunteer to take part in the study by contacting me directly. I will then arrange to meet you at lt to obtain written consent, and talk to you about the inclusion criteria for potential women ants and good practices for recruiting and consenting women.

decide to give consent, I will ask you to share the details of your work rota with me so that I can be t at the unit on selected days that you are working.

k you to discuss the research with women you are allocated to care for when they attend your unit r labour. The women planning to give birth on the unit would already have been given Participant ation Sheets for women at around 34 to 36 weeks of pregnancy, and therefore would have had ime to think about taking part. I will provide you with spare copies of the Participant Information for women an information leaflet to give women a chance to read the information, if they have not o previously.

re satisfied that the women have understood the information I will ask you enquire whether they ling to take part and if so to receive written consent from them. If the women have any enquiries he study, I will be available to answer those, but I will not receive consent from them.

o observe each woman's labour and the care you give to her for up to 6 hours. I am not seeking for recruit women if they are admitted in advanced labour, a time when it may be problematic for to give informed consent. I will not be transferring with women to consultant units if a cation arises in women's labours, or for other reasons. If you consent to participate, I will ask if you be willing to have your care observed on 1 to 2 occasions.

olunteer to have your care observed, I will also ask you to consent separately to being interviewed I would like to audio tape and transcribe the interviews word for word but if you do not wish to be ped, I will make written notes of the interviews instead.

our practice has been observed and you have been interviewed I would like to give you the unity of commenting on my findings. If you are interested, I will send the information to you at idwifery unit and ask you to return comments to me by a certain time using a stamped addressed pe. After that task has been completed, you will not be asked to do anything else.

e a method called framework analysis to analyse the written data gathered and conclusions will be in order to answer the original research question.

king part in the study be confidential? All information about your participation will be kept ntial. The details are included in Part 2.

t details
ave any queries or concerns about the study, you can contact me via the following routes:
01603 597105 (This is my University contact number which I will be accessing regularly)
d.caine@uea.ac.uk

mpletes Part 1. If the information in Part 1 has interested you and you wish to participate, please e to read the additional information in Part 2 before making a decision.

2: What if there is a problem? If you have a concern about any aspect of the study please contact me
l will do my best to answer your questions. If you remain unhappy and wish to complain formally, you
do this through the University of East Anglia complaints procedure details of which can be provided.

u suffer negligent harm because of your participation in the study, please note that the University of
Anglia (UEA) is acting as Research Governance Sponsor for the study. Complaints about harm caused
ne study can be directed towards the Research and Business Services of the UEA (direct dial ----------).
provision of indemnity and/or compensation will be covered by the UEA.

e study identifies unsafe practices in relation to midwifery practice, I will be obliged as any registered
wife to discuss the episode with the person coordinating the shift as would be expected of any
stered midwife. If such circumstances arise I will discontinue the observation.

your taking part in the study be kept confidential?
his is a student project, I am the sole researcher. Once I have collected data from the research site I
store it in a locked cupboard in the university, and in order to maintain confidentiality participants will
dentifiable by a numerical code only. The information linking this number and names of midwife
icipants and women will be held only by me, stored securely on a password-controlled laptop. If I
d to take personal details from you in order to arrange to interview you away from the birthing unit,
information will not be shared with anyone else.

eeping with usual procedure for the UEA, collected data will be retained for a period of 10 years from
pletion of the study, after which time they will be shredded.

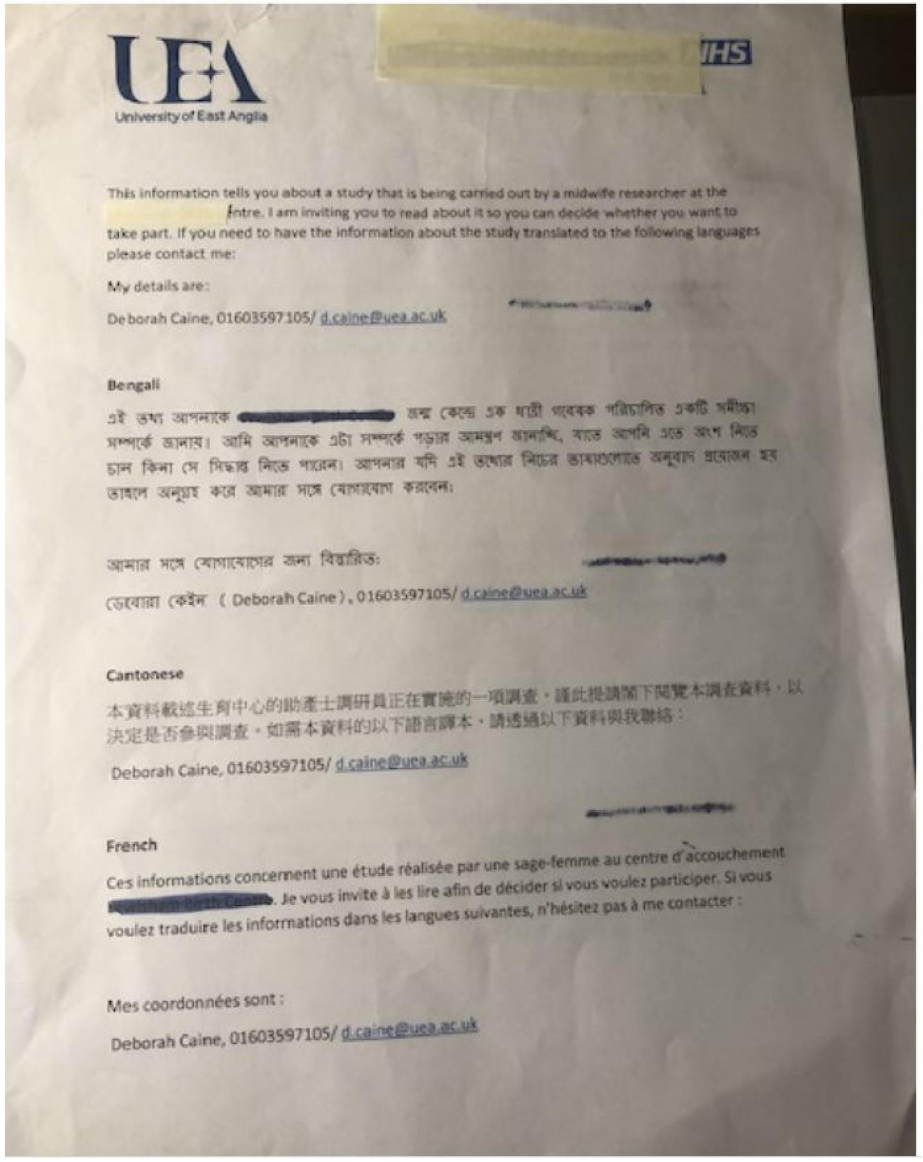
it if you no longer want to take part in the study once the observation has started?
observation of midwifery practice can only take place if participants have given full consent. If at any
t you decide to withdraw consent, for any reason, the observation will be stopped.

it happens to results? The results of the study will be used to complete the research PhD. On
pletion they will be made available in summary form to the participants. The findings will also be
nitted for publication in an appropriate journal. However, you as participants and your birthing unit
not be identified in any report or publication. A summary of the findings will be sent to your unit and
ne local MSLC to be shared with women who use local services. I would like data gathered from the
arch to be available to other researchers, if the request arise, to be reused in the other research. This will
or research purposes only, and all data, including the location of the research sites, will have been made
ymous

is funding the research? A University of East Anglia PhD studentship is funding the research

reviewed the study? The study was given a favorable ethical opinion for conduct in the NHS by the --
----------Ethics Committee.

k you for taking time to read this information.



UEA
University of East Anglia

This information tells you about a study that is being carried out by a midwife researcher at the [redacted] Centre. I am inviting you to read about it so you can decide whether you want to take part. If you need to have the information about the study translated to the following languages please contact me:

My details are:

Deborah Caine, 01603597105/ d.caine@uea.ac.uk

Bengali

এই তথ্য আপনাকে [redacted] জন্ম কেন্দ্রে এক ধাত্রী গবেষক পরিচালিত একটি সমীক্ষা সম্পর্কে জানায়। আমি আপনাকে এটা সম্পর্কে পড়ার আমন্ত্রণ জানাচ্ছি, যাতে আপনি এতে অংশ নিতে চান কিনা সে সিদ্ধান্ত নিতে পারেন। আপনার যদি এই তথ্যের নিচের ভাষাগুলোতে অনুবাদ প্রয়োজন হয় তাহলে অনুগ্রহ করে আমার সঙ্গে যোগাযোগ করবেন:

আমার সঙ্গে যোগাযোগের জন্য বিস্তারিত:

ডেবোরা কেইন (Deborah Caine), 01603597105/ d.caine@uea.ac.uk

Cantonese

本資料載述生育中心的助產士調研員正在實施的一項調查。謹此提請閣下閱覽本調查資料，以決定是否參與調查。如需本資料的以下語言譯本，請透過以下資料與我聯絡：

Deborah Caine, 01603597105/ d.caine@uea.ac.uk

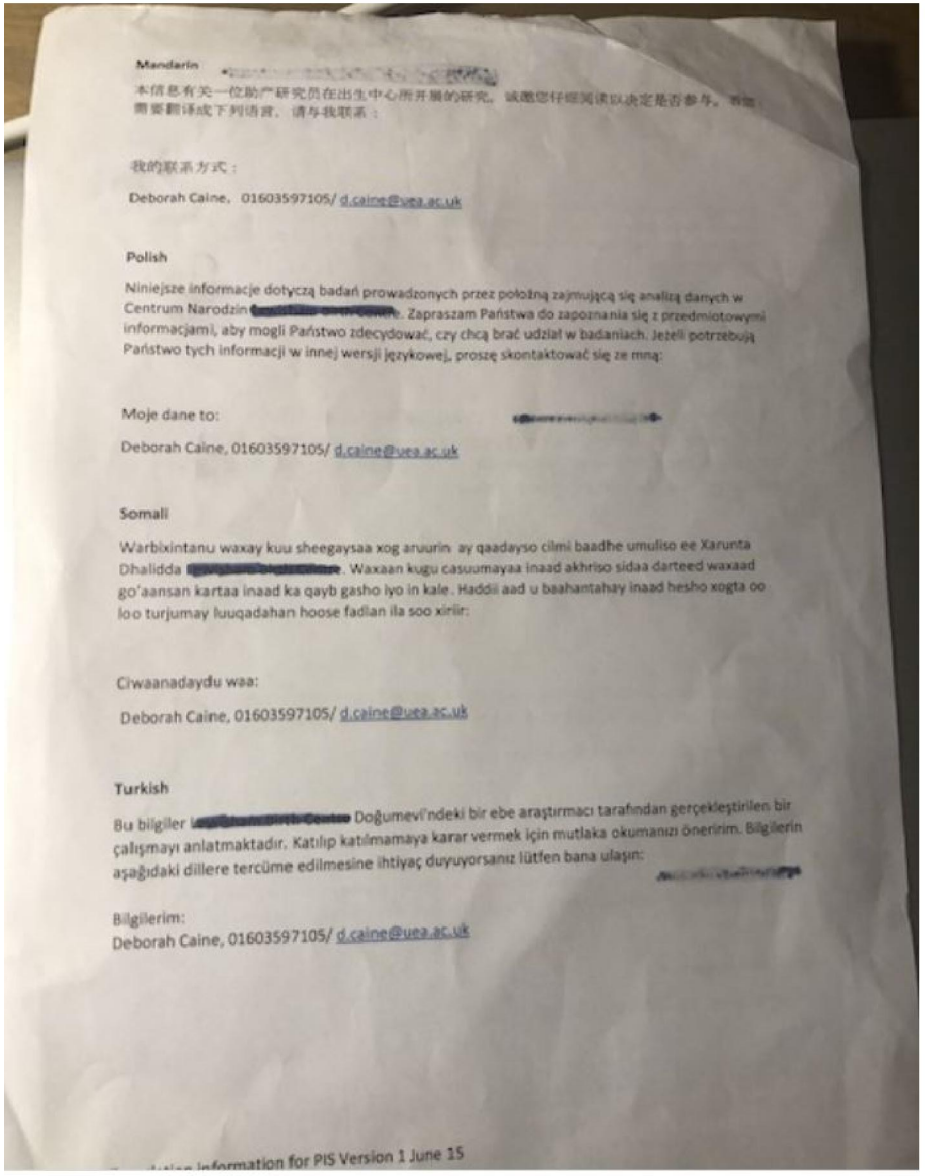
French

Ces informations concernent une étude réalisée par une sage-femme au centre d'accouchement [redacted]. Je vous invite à les lire afin de décider si vous voulez participer. Si vous voulez traduire les informations dans les langues suivantes, n'hésitez pas à me contacter :

Mes coordonnées sont :

Deborah Caine, 01603597105/ d.caine@uea.ac.uk

Appendix 5 Information about translating research information



Mandarin

本信息有关一位助产研究员在出生中心所开展的研究。诚邀您仔细阅读以决定是否参与。如需要翻译成下列语言，请与我联系：

我的联系方式：

Deborah Caine，01603597105/ d.caine@uea.ac.uk

Polish

Niniejsze informacje dotyczą badań prowadzonych przez położną zajmującą się analizą danych w Centrum Narodzin [redacted]. Zapraszam Państwa do zapoznania się z przedmiotowymi informacjami, aby mogli Państwo zdecydować, czy chcą brać udział w badaniach. Jeżeli potrzebują Państwo tych informacji w innej wersji językowej, proszę skontaktować się ze mną:

Moje dane to: [redacted]

Deborah Caine, 01603597105/ d.caine@uea.ac.uk

Somali

Warbixintanu waxay kuu sheegaysaa xog aruurin ay qaadayso cilmi baadhe umuliso ee Xarunta Dhalidda [redacted]. Waxaan kugu casuumayaa inaad akhriso sidaa darteed waxaad go'aansan kartaa inaad ka qayb gasho iyo in kale. Haddii aad u baahantahay inaad hesho xogta oo loo turjumay luuqadahan hoose fadlan ila soo xiriir:

Ciwaanadaydu waa:

Deborah Caine, 01603597105/ d.caine@uea.ac.uk

Turkish

Bu bilgiler [redacted] Doğumevi'ndeki bir ebe araştırmacı tarafından gerçekleştirilen bir çalışmayı anlatmaktadır. Katılıp katılmamaya karar vermek için mutlaka okumanızı öneririm. Bilgilerin aşağıdaki dillere tercüme edilmesine ihtiyaç duyuyorsanız lütfen bana ulaşın: [redacted]

Bilgilerim:
Deborah Caine, 01603597105/ d.caine@uea.ac.uk

[redacted] Information for PIS Version 1 June 15

Appendix 6 Example of framework. Linking data to four defining attribute sub themes: interview data from four midwives. Parts 1 & 2

	A : advocating for women	B : leading care through expertise	C : problematic autonomy	D : Balancing action and no action
RM 1002				
M 1008	. And that's the thing: 'defines it', trying to capture it and explain it is absolutely impossible until you've been doing it yourself for a few years and then it's almost like you have this weird epiphany of 'right, this is what is happening' 'this is what goes on'. And in yourself as a midwife you have to gain that trust in birth. That's something that you can only do and experience. No Mayes or Myles is going to tell you how to do that. You have to just do it.	And in yourself as a midwife you have to gain that trust in birth. That's something that you can only do and experience. No Mayes or Myles is going to tell you how to do that. You have to just do it.	For me, I mean, this is, I think that the most important thing a midwife should be is humble. And I also think that the most important thing that a midwife should be is zero ego, none, none at all. So, for me, autonomy, in the sense that, I don't want every Tom Dick and Harry to come through the door and see my woman. Because, because for her privacy, for her oxytocin levels, for her to have that physiological birth it's not helpful; cos that's where it starts and ends with me. Because I'm not autonomous, actually, I work in a sister hood almost. As a movement we're autonomous, and that's what I really like about midwifery. But as an individual, I think, safety in numbers. So autonomy, for me is all about advocating for the woman, that's fine. But as a practitioner, as an individual, it's of no importance to me to make my own autonomous decisions. I don't have to fight a doctor. I don't see it that as autonomy, like you know, some midwives are like 'Oh and I didn't let the doctors in....' and I just think: that's good for you but I hope you did that to protect your woman, not because you think that you're dealing with this and you're fine; that's very different. So why, why, we always have to look why we're being autonomous, in my opinion. Are you doing it for your woman, because in that case that's fine. Or are we doing it because we've got these big old egos and we think that we#re so great.	if you think about examples of trying to do the right thing with, I dunno, like nature for example, em, people that are trying to observe nature for example, this is a really weird example, but I dunno, documentary makers, they film things. They never intervene, they never, I dunno, If you've ever sat down and watched, like David Attenborough documentaries you think:'ugh, save the seal' they never do that because that's, that's nature. Midwifery for me is very much the same. You are there to empower what nature is going to do, and what that woman's going to do. There to, of course you are there to stop dangerous things from happening and all the rest of it, em, but you're not there to direct her in anyway other than the route that she's gonna take but I think it could be underestimated how challenging it is to give care on a low risk midwifery unit, midwifery led care because you really have to use your brain all of the time and actually caring for a woman without pain relief can be quite physically and emotionally quite emotion draining because ... because she's ... she's drawing on almost, well not almost, she's drawing all of her reserves and it's quite challenging to support her and see her going through this process sometimes because you ... you do want to just act like, ok I've got this thing upstairs called and epidural, we can just end this now (laughs softly) Sometimes when they are really struggling, but you're not gonna do that because you know that the overall outcome is gonna be a really lovely low risk birth. She's gonna go home a few hours later with a baby; it's gonna be fine (smiles), most of the time Because if she, if she has any (said with emphasis) sort of anxiety that's gonna, that's gonna alter the oxytocin levels in her system, that's gonna hold back the process, So, for me, autonomy, in the sense that, I don't want every Tom Dick and Harry to come through the door and see my woman. Because, because for her privacy, for her oxytocin levels, for her to have that physiological birth it's not helpful; cos that's where it starts and ends with me so actually why don't you just step back, let mother nature do it's thing, and let the women lead the care. And let the women tell you, cos we're only midwives as long as women wants us to be?

RM 2003			Em, my understanding is that midwifery, midwife takes, em, charge. Em, so they look after the women and, and they, they... from antenatal to intrapartum to postnatal care. So just midwives. Em, my understanding is that midwifery, midwife takes, em, charge. Em, so they look after the women and, and they, they... from antenatal to intrapartum to postnatal care. So just midwives.	

Framework matrix - coding at 2 defining attributes

RM 2015	You know there are women here that refuse to transfer, when they've had a PPH or something and you say 'ok, look, we'll try and get round this. And they've remained, because you can't make a woman go. I think that's the really lovely thing, to involve women with their (emphasis in midwife's voice) decision making. And as the only experts here, they really listen, and they really honour that.	Midwifery led is also being in a room where you are the only expert in the room making clinical decisions and that becomes very sensory based, very intuition based, so it's a look ...you're decision making all the time on a midwifery led unit. There's no emergency buzzer where someone's gonna save you. So it really tightens up your skills. And it makes you make decisions much ... far before you would normally make decisions, and there's a lot of conversations you have with women: 'we've been going at this labour now for some hours and we've tried this, I think we should start talking about, within the next hour, what we're gonna do' .... Its those conversations you had ... have before now, that you don't do at a hospital. So the woman is far more engaged with her care. And this is something that we talk about antenatally and at the 36 weeks appointment when they come, cos they'll always ask about transfer and you say 'look, it's a decision we're making together'. : So first it's about de-schooling, to stop relying on ... first you need to learn to SBAR really quickly, to take all the evidence and knowledge that you have and say 'this baby is stuck'. 'This baby ... we have a protracted labour. This baby is not moving, its asynclitic, I'm pretty sure by my examination ... we need to move, it's not gonna work'. Right? This is the conversation we have with a midwife: 'this woman's dehydrated, she needs ... ' it's those sort of things. You've gotta use your own knowledge base first, SBAR that woman and don't tell me 'oh I think she's quite dry' or 'I think the head ... ' We've stopped talking like that. You have to be really definitive. You are that person looking after that woman. Your skills and drills have to be shit hot. And it's based on your knowledge and your decisions with someone else, and being open to criticism, open to someone saying: 'well actually, it's been 6 hours of the same, where did you want to go with this? She really wants to stay but we've got to think of her safety. Do you mind if I feel of her tummy, and let's ... let me take over for 2 hours and see what I think?' Because it's quite fine, I've been so tired before, I've come out going 'I can't see the wood for the trees, I need someone else to just kind of get a head on this labour'. And I think that should be encouraged	I love the decision making process that midwives have when we don't have doctors around. Em .... and its great having supportive higher management team or supportive obstetricians that believe in this care, which we've had for years actually. We've had really good obstetricians that have encouraged us to be more SBAR, more decision making. So we'd write an email saying 'she's now not within our criteria, could you do this'. it was quite difficult to get my mind around it, the decisions making. Because I'd been so used to referring always to a doctor to make simple decisions. Whereas, you realise in midwifery led care it's the hard decisions that do need a group mentality. It needs 'I think this, what do you think? What could happen? And it's opening those conversations. And I think that's true midwifery led care. I love the decision making process that midwives have when we don't have doctors around. Em .... and its great having supportive higher management team or supportive obstetricians that believe in this care, which we've had for years actually. We've had really good obstetricians that have encouraged us to be more SBAR, more decision making. So we'd write an email saying 'she's now not within our criteria, could you do this'. it was quite difficult to get my mind around it, the decisions making. Because I'd been so used to referring always to a doctor to make simple decisions. Whereas, you realise in midwifery led care it's the hard decisions that do need a group mentality. It needs 'I think this, what do you think? What could happen? And it's opening those conversations. And I think that's true midwifery led care. I love the decision making process that midwives have when we don't have doctors around. Em .... and its great having supportive higher management team or supportive obstetricians that believe in this care, which we've had for years actually. We've had really good obstetricians that have encouraged us to be more SBAR, more decision making. So we'd write an email saying 'she's now not within our criteria, could you do this'.	

Appendix 7 List of documents collected for document analysis

A sampling of documents and data analysed

Matching each document against the pre-existing defining attributes of midwifery led care

Method used consisted of sampling, data coding according to codes from the study (deductive and inductive) and interpreting them in light of the findings to date.

Data consisted of guidelines, information sheets about particular conditions which were made available to women, consumer reports of the birth centre, press reports, and feedback forms given to women, etc. Reports of document analyses from the literature have taken similar approaches (Slakoff and Brennan, 2019; xxx), and give similar rationale for using this method of data collection.

Documents were collected during the time of conducting filed work in the two cases, by purposive sampling.ch of the cases had a plethora of documents

displayed in the staff only offices, and examples of the documents were selected by the researcher as examples of what participants had at their disposal to refer to.

Access to documents: most of the documents were in the public domain, meaning that they were freely available to the women and whoever accompanied them, information sheets and feedback forms fell into this category

Documents selected/date/ author/code for document	Description of data analysed	Comments Link with defining attribute theme. **DA 1 Defining attribute theme 1 etc**	Connection to defining attribute theme?
PIL May 2014 **What happens when your waters break before labour?** **Doc 1.01**	Information for women explaining pre labour ROM	Outward facing Clinical. Perfunctory information. Generic information found in all areas of maternity. No specific mention of birthing centre. Women advised to call delivery suite (OU) i.e., directed towards delivery suite for the initial contact. Quantification of the issue given. Neutral tone. Not necessarily a problem as 1 in 5 women experience it spontaneously. Inductive themes: preserving self – collective consciousness which is distinct from the OU.	This document is an indication of the connection with a larger organisation. It is general information to women using all of the Trust intrapartum services. Description is given of the issue of pre labour rupture. Management is laid out without options given. This information also shared with women using the birth centre, reinforcing the relationship to the wider maternity service as being primarily medical management. Aspects that show the MLU is part of the culture of the medically led maternity services. Implication is that advocating for women who do not desire to follow the pathway is therefore an option particular to the MLU, rather than 'mainstream'.
Guideline **Birth Centre Clinical Guideline May 2015** **Matron for Birth Centre** **Lead midwives for centre** **Consultant Midwife** **Doc 1.02**	Clinical recommendations for management of labour on the birth centre	Inward facing. Specifies leadership roles and responsibilities. And responsibilities of individual midwives. Responsibilities for individual, band 6 midwives, did not specify leadership qualities and activities. DA 1 - advocating DA 4 • 'Preserving self' theme birth – need to prove highly technical skills such as assessing deteriorating conditions using standardised SBAR tool	Emphasises the criteria for using the birth centre, some flexibility. Individualised care plan with obstetrician/clinical midwifery leader if 'amber' risk assessment. Philosophy of care is included, but document more oriented towards risk assessment, and urgent/ emergency measures. During data collection MLU midwives were ambivalent about the support they would get from mgt when supporting certain women. The need for midwives also to feel safe not referred to. The requirement to use SBAR communication tool mirrored MLU findings about SBAR skills needing to be well honed. Recognition of the need for coordinated transfers. During data collection MLU midwives expressed difficulty in being treated respectfully around the need to transfer women. Though the guideline specifies wider team approach and escalation strategy MLU midwives saw themselves as being alone in those circumstances. The need to remain with the woman transferred, a recommendation, left MLU midwives feeling that they were being taken advantage of, and leaving the MLU staffing unsafe.
Written information welcoming women to the birth centre	Information about how the birth centre works and what the process is for calling.	Outward facing • DA 2 – knowing and understanding normality. Belief in physiology, birth as	Informative and congratulatory. Interesting was the discouragement from coming to the BC and the 'threat' of not being able to remain if

Author: Senior midwife at MLU **Not dated: in use at time of data collection.** **Doc 1.03**	Suggestions about care in latent stage of labour	a social reality and not a medical one requiring surveillance. • DA 4 -contradiction with the ethos of individualised care through denying access unless an arbitrary point has been reached, which may not accord with a woman's needs/ making decisions about care	not in established labour amongst the affirmation of normality. This more accords with medicalised view of labour being a linear process; the findings indicated a flexible and more individualised approach to women. Advice that is given is based on 'homely' and 'social' measures that affirmed women's capability and possibility of being in control.
'Which' report of the MLU, Updated 2017 **Doc 1.04**	Information from consumer advice organisation to help women make choses about place of birth	Outward facing. Description of the service offered • DA 4 decision making	Indicates more flexibility about care in latent phase: several options (other than being sent home), possibility of women being involved in the decision making and care based on individual needs. Eligibility criteria does not reflect the flexibility of the Trust guideline and is v general. This is more accessible to women than Trust guideline. Describes 24 hour visiting for one nominated birthing partner. Findings suggest more flexibility in practice
The Latent phase of labour. Trust document dated May 2015 Written information to women about coping in the latent phase of labour **Doc 1.05**	Information for women at term pregnancy (37-42)	Outward facing Inductive themes – collective consciousness and a dichotomy of difference. Tensions with the wider organisation, or indication of being linked to the wider Maternity services with greater acceptance of standardisation	Medicalised writing. Emphasises and discourages women from coming into hospital at this point, more negative about hospital than positive about home environment. Pictures taken are designed to inform women about the cervical changes but are similar to those used in midwifery textbooks. Suggests that spontaneous rupture of membranes is normal at this gestation but recommends coming in for a check. Locating pregnancy in the domain of medicine and risk. Indication of being part of a wider service with influences from obstetric 'point of view'. MLU midwives talked of different points of views between them and their OU colleagues. But it might also be the need to have your feet in both camps. Midwives did fluctuate towards those opinions sometimes (e.g., use of guidelines). Discourse of normal vs language of technical experts By contrast, advice about what to do at home is in the social domain, ordinary activities within the woman's control. Emphasising that nothing is wrong. Coping mechanisms that are commonplace, putting them into practice is straightforward. Belief in normality and women's ability to manage labour with minimal intervention.

Orientation list for non-birth centre staff (on notice board, undated) **Doc 1.06**	Information for midwives and other staff who are not familiar/core staff	Inductive theme - gatekeeping	Commences with a statement about empowering women. At the same time guidance about primips being admitted at 4 cm, thus prescriptive and steering unfamiliar midwives into the way of thinking. The information given is procedural: communicating with the bleep system, location of emergency equipment, what happens to keep newcomers in line is takes place more through non-verbal or indirect means.
Information for women: postnatal information pack for new parents **Doc 1.07**	Information for women using both post-natal wards of the NHS Trust.	DA 3 relationships and looking after partners	
Eight TIPs for normal birth Undated, reproduction of an entry in The Midwives labour and birth handbook ed Vicky Chapman **Doc 1.08**	Reproduced advice for facilitating and encouraging normal birth. Explicitly accords with ways of practising and ideas MLU midwives had as core values.	DA 1 advocacy DA 2 knowing normality/ balancing action and no action	Most of the tips are directly related to the DAs
BC Student welcome pack **Doc 1.09**	The content of the pack is for students who have placements on the birth centre. The work of the BC is highlighted: Women- centred care, low risk women wanting an alternative to the medicalised environment on labour ward. The philosophy about offering comfortable homely surroundings to ease the birth process. Provision of calm and relaxing environment. Women centred takes into account needs and wishes of women and partners, being open minded and flexible and engaging with techniques that augment neurohormonal process and include psychotherapeutic processes. The BC supports active labour and encourages mobilisation. They believe this leads to a decrease in anaesthetic pain relief and need for instruments and satisfaction with birth. Opportunities for waterbirth,	Directed at students, orientating them, and welcoming them, and also preparing them for the environment. Declaration of the aims and philosophy. Open codes: gatekeeping, teamwork, collective consciousness, preserving self	

	phys third stage, active birth, hypnobirthing, skin to skin		
Positions for labouring out of bed **'Childbirth Graphics' 2005** **Doc 1.10**	Drawings of different positions women could get into. Not relying on labouring in bed. Graphics designed by commercial company and used as flyers/posters in birthing rooms.	DA2 facilitating physiological labour through active birth	Suggestions of options for maternal physical positions, based on understanding of effects of gravity and movement on progress in labour. Leaflet distributed at active birth class, and available in MLU for women and midwives to refer to.

Documents selected/date/ author **FMU Case 2**	Data analysed	Comments Link with defining attribute theme specified? **DA 1 Defining attribute theme 1 etc**	Connection to defining attribute theme?
Public report of MLU incorporating data from audit as well as studies carried out on the MLU. **Authors: PhD Researcher, Senior Midwives, NIHR Fellow, University professor (2016)** **2.01** **(Audit for 2015 shared with researcher. Author: Band 7 FMU midwife** **Results of this audit contained within the report and not looked at separately)** **Doc. 2.02**	Audit data collected from 2008 to 2018 i.e., first 10 years of the MLUs operation. Relationship to current study.	DA 3 Continuity of carer DA 1 advocacy DA 3 relationships	The document reports on continuity of carer and how it has been adapted for the MLU setting. It is described as a goal for the midwives to achieve. The levels of continuity were nearly 10 times that of women giving birth at the host OU (p28). Linked to the third DA with emphasis on continuity models. Opinions varied about the value of continuity: advantages but difficult way to work, as well as not necessarily a priority for women, who just wanted the midwife to be kind. The document reported on partnerships built with women, personalised care. Document highlights establishing a rapport, giving information for women to make the decisions, respecting autonomy. Document outlines the positive perinatal outcomes and discusses safety in general. Findings suggest that MLU staff do not have a sense of being viewed as safe
FMU information leaflet for potential users. **Author is NHS Trust 2014** **Doc. 2.02**	Information given to women about the services available from the Trusts MLUs, one of which is Case 2	DA 2 Idea of providing the facilities to promoter normality DA1 leaderships and autonomy	Refers to expertise of midwives. Discusses inclusion criteria as women with straightforward pregnancies. No indication of flexibility, so some contradiction with idea of personalised/individualised care Highlights positive outcomes for women using the MLU. Promoting natural birth Offers statistic of transfer rates, lower that those quoted in Birthplace study.

Documents selected/date/ author **FMU Case 2**	Data analysed	Comments Link with defining attribute theme specified? **DA 1 Defining attribute theme 1 etc**	Connection to defining attribute theme?
			Gives a positive impression of the service, impression of self-assured, confident, and safe leadership from the midwives.
Trust FMU and homebirth guideline, criteria appendix to main guideline **Author: NHS Trust** **June 2017** **Doc. 2.03**	The criteria used to decide suitability for FMU and homebirth.	This document is an appendix to the guideline and sets out inclusion criteria. The idea of accommodating individualised plans does accord with participants' opinions about women having choices. The document lays out intermediate risk factors. Most of the comments about using or not using guidelines were related to 'normal' women. When confronted with an actual deviation there were still commitments to give women choices, although not being wholly comfortable, and needing support. DA 1 autonomy DA2 Knowledge	Opening statement is about supporting normal birth, importance of environment, and the importance of safety given that the transfer time to an OU. Prescriptive about women fulfilling criteria but concedes the possibility of having an individual plan of care, also considering AMU. Intermediate risk factors require an individualised care plan by the named midwife with input from appropriate MDT. GB strep 'requires' antibiotics. Light meconium staining requires women to be transferred to the AMU
Reflective case studies **Doc. 2.04**	Records of ad hoc reflective sessions on women's cases. They were informal and collegiate meetings open to all.	This was an opportunity for midwives to interrogate the service, to scrutinise what midwifery practice had been in a particular case and learn from experiences. It was a vicarious debrief of feelings. opinions and ideas. I participated in one session. A woman had transferred to the OU, and the discussion was about what happened to get to that stage and what happened from then. Midwives love a good story to unpick and critique. DA2 Knowledge DA4 Decision making influences Inductive themes: gatekeeping	How midwives build on knowledge through group discussion and critique How midwifes interpret decision making Gatekeeping and coalescence of opinion of midwives coming in to the collective ideas of existing MLU midwives.
Customised Drills and Skills for Birth centre staff – information **Doc. 2.05**	Proforma for Drills and Skills	FMU plans for D&S twice per month to be led by a band 7 midwife. Customised training taking into account the particular environment DA1 D2 Inductive theme: preserving safety	Identifying clinical leaders and responsibility for safety Reinforcing the place of theoretical rational knowledge
NHS Trust values **Doc. 2.06**	Display of vision and values of the Trust	Demonstrates the connection with wider maternity services	

Documents selected/date/ author **FMU Case 2**	Data analysed	Comments Link with defining attribute theme specified? **DA 1 Defining attribute theme 1 etc**	Connection to defining attribute theme?
Feedback for women and families **Doc. 2.07**	Display of feedback including recommendations for improvement	Part of a service that needs to take account of women's experience	
Orientation programme for midwives updated 2010 **Author Practice development midwife – Trust wise** **Doc. 2.08**	Directed to midwives joining the Trust. Statement of unit philosophy' respect for pregnancy as a state of health and childbirth normal physiological process. Respect for diversity of needs and personal, cultural of women and families. Non authoritarian care responsive to social and emotional needs. Professional responsibility to encourage shared decision making. Evidence based information, education, and counselling	Statement is emphatic. Social model of childbirth. Respecting diversity significant due to diversity of the setting of the Trust. Stress on egalitarian decision making and evidence based practice. DA2 DA4	Belief in childbirth normality Shared decision making Implies a shared philosophy across the Trusts' maternity services which MLU midwives challenged.
Minutes of team meeting June 2017 **Present were managers, consultant midwife, birth centre staff** **Doc. 2.09**	Items on the agenda – typical of any maternity unit: staff shortages, effect of 'on-calls' on health, ongoing audits.		
Information for birth partners **Handout used in birth preparation. No author** **Doc. 2.10**	Suggestions for helping women in labour. Active birth, environment, oxytocin	DA2 DA3	Knowledge of what facilitates normal birth Recognising partners
Eligibility assessment for FMU **No author** **Doc 2.11**	Assessment of women for place of birth recommendations	DA2	Forms of knowledge relied on by midwives
Ten year celebratory booklet **Doc 2.12**	The FMU produced a document to celebrate 10 years since being opened. Included philosophy of care and audit details	Inductive theme: protecting self	Audit data. Nominal reduction in births since AMU opened

Doc109	environment on labour ward. The philosophy about offering comfortable homely surroundings to ease the birth process. Provision of calm and relaxing environment. Women centred takes into account needs and wishes of women and partn e rs, being open minded and flexible and engaging with techniques that augment neurohormonal process and include psychotherapeutic processes. The BC