A phenomenological exploration of midwives accounts of midwifery expertise

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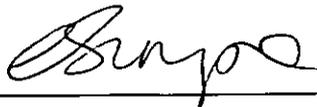
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Abstract

A phenomenological exploration of midwives accounts of midwifery expertise

Aim: This thesis reports the findings of a qualitative study which aims to explore the nature of intrapartum midwifery expertise using a phenomenological approach, in order to illuminate the essential characteristics and skills that facilitate optimal birth outcomes for women. The primary aim of the research was to gain an in-depth understanding of the meanings midwives place on the; 'nature of midwifery', 'normal birth', and 'expertise in childbirth', exploring these meanings in a cultural context.

Background: Expertise in the context of nursing and medicine has been subject to much exploration and debate. However, there are very few studies of practitioner's accounts of expertise in the context of midwifery intrapartum care. Despite this, it is not uncommon for midwives to pronounce themselves the experts in, or guardians of normal childbirth. However, the statement appears to rule out expertise in situations where childbirth is not normal. As the majority of women giving birth in the UK currently do not experience a physiological birth, and indeed in many countries across the world, this raises questions both about the claim to expertise in normality, and its apparent demise, and about the provenance of midwifery expertise in general.

Methods: A systematic review was undertaken in which twelve databases and fifty relevant journals were searched for papers published between January 1970 and June 2006. A subsequent qualitative study took an interpretative phenomenological approach. Group interviews (n=4) and in-depth individual interviews (n=3) were used to capture data about the lived experiences of midwifery, normal childbirth, and expert intrapartum care.

Findings: Data from the qualitative study identified fourteen codes (knowledge, experience, education, personal attributes, confidence, competence, judgement and decision making, technical and fundamental skills, belief and trust in birth, courage,

intuition, midwife-woman relationship, midwife colleague relationship, and creating an environment of trust) which were combined to form four themes; 'wisdom', 'skilled practice', 'enacted vocation', and 'connected companionship'. Findings of this study suggest that there are three domains of expert midwifery practice; 'physiological expertise', 'technical expertise' and 'integrated expertise'. Integrated expertise appears to be the strongest of the three, being characterised by the expert's ability to work across boundaries of normality and through differing models of care in order to promote optimal birth outcomes for women.

Conclusion: Experts appear to negotiate the dichotomy between the medical and holistic model of care, subtly integrating the art and science of midwifery. As experts appear to overcome many of the cultural problems evident in practice, they may be regarded as valuable role models. These attributes may be used to challenge practice, in order to accommodate or overcome dissonance between different models of practice. This would in turn benefit the profession in terms of recruitment, retention and professional status.

Data from this study add new insight to the nature of expertise. Data relating to midwives' attitudes, and the relationships that experts build with colleagues, appear to be significant new findings, and important concepts in the development of expert practice. However, further research would be required to identify and explore the domains of expertise proposed in this study.

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Section One

Section Two

1.0 Introduction

This thesis forms part of a Masters by research and aims to explore the nature of intrapartum midwifery expertise in order to illuminate the essential characteristics and skills that facilitate optimal birth outcomes for women.

It includes a three stage process; (1) systematic literature review; (2) group interviews; and (3) individual interviews. Phase one (the systematic review) and phase two (group interviews) were funded by the authors employer (East Lancashire Hospitals NHS Trust) as part of a research programme within the Trust. There were three members of the research team; Louise Simpson (the author); Soo Downe[1] and Katriona Trafford[2]. Phase three (individual interviews) were subsequently conducted during the masters programme and self-funded by the author. The masters programme was funded by the Florence Nightingale Foundation and East Lancashire Hospitals NHS Trust and sponsored by University of Central Lancashire.

Initially, the focus was on aspects of normal childbirth and on expertise in this specific domain of practice. Thus, some of the data about normality and expertise in this area may have been prompted by the group interview guide. However, the focus of the research changed during the process of the research and writing of the thesis. Thus, the work became more about expertise per se, with expertise in normal childbirth being one characteristic on a spectrum of expertise.

The subsequent follow up individual interviews were prompted by this change in focus, to explore individual midwives' experiences of and meanings attributed to intrapartum expertise. Using a phenomenological approach, the interviews were started with one lead in question; *'I want you to think of someone who you regard an expert in intrapartum care. Tell me about your encounters with that person (or a specific encounter that best demonstrates his/her expertise'.*

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Data from the follow up interviews identified a spectrum of intrapartum expertise ranging from experts in high risk care (technical experts) to experts in low risk care (physiological experts). However, all participants in both the group interviews and individual interviews identified that one essential characteristic of expert practice was the ability to promote and practice physiological childbirth in any clinical setting. The term 'integrated expert' has been used to describe this specific domain of intrapartum expertise.

Thus, it appears that expertise in normal childbirth appears to be a significant aspect of expert midwifery practice. Given the current international concern about the increasing rates of routine intervention in childbirth and the apparent demise in the rates of normal birth, the findings in this thesis provide an important insight into ways in which these trends may be challenged or reversed.

2.0 Current context for midwifery practice

Introduction:

The aim of this chapter is to present an overview of current midwifery practice. The first section of the chapter will address both the cultural changes and the context of childbirth practices. Section two will explore the nature of midwifery. The third section will present an overview of the history of childbirth practices. Section four and five will briefly explore the concept of normal birth, and its relevance to maternity care expertise. The final section will highlight the way forward, and how midwives can overcome the challenges presented in this chapter.

2.1 Cultural context of childbirth practices

Maternity care has undergone many changes during the past few centuries. During the 20th century in particular, care during childbirth has changed considerably in the UK. The implementation of the NHS (1948), and the later Peel Report (Department of health and social security 1970) have had significant consequences on maternity care. Many critics have linked this with a care delivery system termed the 'medical' or 'technocratic' model, which appear to have become the cultural norm in most Western Countries (Davis-Floyd 1993; Anderson 2002).

The focus of the so-called medical model is on *'the indicators of disease rather than the individuals experience of health and illness'* (Cahill 2001, p339). The medical model views the woman's body as a defective machine in need of surveillance and control, requiring technological management (Blaaka & Schauer 2007).

Davis-Floyd (1987) suggests that the technological model of birth *'utilizes the assembly line production of goods as its base metaphor for hospital birth'* (p479). In a later paper, Davis-Floyd (2001) claims that the hospital has become the factory, where the mother's body may be described as the machine, with the baby being the product of an *'industrial manufacturing process'* (s6). However, the ideals of the medical model do not always reflect or meet the individual needs of labouring women (Turkell 1990).

Consequently, attempts have been made to challenge this so-called 'medicalisation' of childbirth through promotion of the social model of health. The social model may be described as a preservative approach which maintains physical and psychological health and wellbeing (Cahill 2001). The classic midwifery philosophy and the social model of care promote pregnancy, labour and birth as a normal, natural process (Fullerton et al 2005). Emphasis is placed on birth as a whole, and supported through attending to the physical, social and emotional needs of the woman and her family (Davis-Floyd 1994).

2.2 The nature of midwifery

According to the World Health Organization, the international definition of the midwife is; *'A midwife is a person who, having been regularly admitted to an educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant...'*(WHO 1992).

In response to international concern about the increasing rates of intervention in childbirth (Downe 2006), the International Confederation of Midwives (2005) reviewed and revised the definition of the midwife to include; *'The midwife is recognized as a responsible and accountable professional who works in partnership with women to give necessary support, care,......This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child...'.* Thus, emphasis is now placed on the promotion of normal birth, the accountability and professional status of the midwife, recognising the midwife-woman relationship as a partnership (Duffi 2006).

In response to the increasing so-called medicalisation and technicalisation of birth, the Royal College of Midwives are currently promoting normal birth through their 'campaign for normal birth', demonstrating commitment to maximising and promoting normal childbirth. They suggest that *'midwives' are expert professionals skilled in promoting and maximising normal birth and their skills need to be*

promoted and valued. The role of the midwife is integral to models of care which promote normality' (RCM 2007).

Thompson (2004) suggests that midwives claim to be the guardians of normal childbirth. Indeed, Downe (2006) proposes that normal childbirth *'is held to be one of the key areas of expertise of midwives'* (p352). Anecdotally, it is not uncommon for midwives to pronounce themselves 'the experts in normal childbirth'. This pronouncement goes largely unchallenged and is seen as a matter of some pride, and even as a fundamental statement of identity. In this usage, it is assumed that the term 'expertise' does not need explanation. The statement also appears to rule out expertise in situations where childbirth is not normal. However, the majority of women giving birth in the UK currently do not experience a physiological birth (Williams et al 1998; Downe et al 2001) and it is likely that this situation is similar in many countries across the world;

'As normal birth becomes a minority, so do the practitioners who want to support normal birth. Not only does it become uncommon, and therefore more uncomfortable and difficult to support natural processes, but it also means that skills and confidence are lost' (Page 2003, p356).

This raises questions both about the nature of expertise in normality, and its apparent demise, and therefore about the provenance of midwifery expertise in general.

2.3 Normal birth: the problem with definition

The failure to define normality may have contributed to the increased medicalisation and technicalisation of birth (Gould 2000). Definitions of normal labour and birth have been subject to much exploration and debate (Beech 1997; World Health Organisation 1997; Gould 2000; Downe et al 2001; Anderson 2003). At one end of the scale normal birth means 'physiological birth', birth without any interventions to alter or hinder the normal birth process. At the other end of the scale, birth may be considered 'normal' if the outcome is that of a vaginal delivery, without the use of instruments. Any interventions during the labour process not being taken into consideration (Anderson 2003). A study conducted by Downe and colleagues (2001), which examined 1464 birth records, suggested that 62.3% of the 956 births which had

been documented as 'normal' or 'spontaneous' had actually included one or more of the following interventions; induction of labour, acceleration of labour, ARM, epidural, or episiotomy. By using the AIMS definition of normal birth (Beech 1997), only 24.6% of the 1464 births occurred physiologically without intervention.

2.4 The decline in normal birth

Over the past decade, the rate of 'normal' birth has rapidly declined. Using data from Birth Choice UK, the rate of normal birth (in the UK) has declined from 59.7% in 1990, to 46.7% in 2006. Instrumental delivery rates have increased from 9.4% to 11.1% during the same time period. The most significant increase may be observed in the dramatic rise in caesarean section rate, from 11.3% in 1990, to 23.5% in 2006. It could be argued that this is unimportant, if the reports of accelerating rates of pharmacological and technological interventions in labour in the UK, and indeed most parts of the world, do not give rise to concern for the wellbeing of mothers and babies (Downe et al 2001; Thomas and Paranjothy 2001; Downe et al 2007). However, many health professionals, policy makers, and service users have recognised the problems associated with both the rapid decline in normal birth and increased use of interventions in childbirth (DOH 1993; Royal College of Midwives' 2000; Johanson and Newburn 2001).

Midwives over-reliance upon technology may be argued to devalue traditional midwifery knowledge and skills (Lavender et al 2002). Research into traditional midwifery knowledge and skills, or into what makes midwifery or midwives unique at what they do is sparse. It appears that high-risk obstetrics and increased use in technology is trusted more than midwives unique skills at facilitating normal birth (Faby 1998). This has resulted in midwives extending their role to undertaking ventouse deliveries, examination of the newborn, and assisting in caesarean section (Lavender 2007). There appear to be two arguments proposed for the implementation of such extended roles; the first being to meet the needs of their clients (Lavender 2007) and the other to compensate for the medical dominance of childbirth (Taylor 2001). However, it may be argued that many extended roles devalue normal childbirth, have taken midwives away from their supportive role, and as a result

midwives have become disempowered (Edwards 2000; Lavender 2002; Thompson 2004).

2.5 The way forward: facing the challenge

It may be that the culture surrounding birth and the environments in which many midwives work has resulted in midwives reporting burnout and stress due to the conflicting ideologies of physiological and technocratic birth. In birth environments dominated by a medical or technocratic model of care, both women and midwives may find it difficult to challenge the ethos of *'that's how things are done here'* (Kaufman 2000). Curtis et al (2006) suggest that the loss of trained midwives from practice in the UK may be partly explained by midwives' perceptions that they are unable to practice as 'experts in normality' in current labour ward environments. It is therefore important to explore what skills, attitudes and beliefs make specific midwives 'expert' or unique. This may help midwives to regain their confidence, allowing them to facilitate optimal birth experiences for women.

The following chapter presents the evidence surrounding the concept of nursing, medical, and intrapartum maternity care expertise.

3.0 The notion of expertise

3.1 Introduction

In the current healthcare system evidence based practice and quality issues appear to be high on the political agenda (Christensen & Hewitt-Taylor 2006b). It may therefore be taken for granted that expert practice is also high on such political agendas (Hardy et al 2002). However, expert practice may be argued to be an elusive phenomenon (Peden-McAlpine 1999). Although Jasper (1996) suggests the term expertise appears to have common meaning, *'it is apparent that when used in nursing it refers to a multitude of attributes and lacks clear definition'* (p789). This chapter aims to explore the concept of expertise and present an overview of medical, nursing and intrapartum maternity care expertise.

3.2 Expertise

According to the Longman online dictionary[3], an expert may be defined as *'a person who is very knowledgeable about or skilful in a particular area'*. Other online dictionary sources define experts as *'someone who has a special skill or special knowledge of a subject, gained as a result of training or experience'*[4], or *'one whose special knowledge or skill causes him to be regarded as an authority'*[5]. From these definitions it would appear that both knowledge and experience are fundamental to expert practice. However, how experts utilise this knowledge and experience into expert practice is not evident from the definitions proposed.

Although the concept of expertise has been the focus of much debate, there appears to be much confusion and controversy surrounding its definition and how expert practice is achieved. The work of Patricia Benner (1984) who adapted the Dreyfus and Dreyfus (1986) model of skill acquisition appears to be most influential in the concept of nursing expertise. A summary of both is presented below.

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[3] http://www.askoxford.com/ accessed 17/07/07
[4] http://www.ldoceonline.com/ accessed 17/07/07
[5] http://dictionary.oed.com accessed 17/07/07

3.3 Dreyfus Five-stage model of skill acquisition

Based on a study of chess players and airline pilots, this model proposes that expertise is developed through five stages; from novice, through advanced beginner, competence; proficiency and finally expertise.

Novice: At this stage the novice relies on rules to govern practice and performance.

Advanced beginner: As the novice gains experience, he/she develops an understanding of the context of the situation. Dreyfus proposes that an advanced beginner chess player would with experience be able to recognize situational positions which they would respond to (Dreyfus and Dreyfus 1986).

Competence: Through encountering various experiences, the competent learner is able to choose the appropriate plan or take appropriate action. At this stage, the learner takes responsibility for decisions made. Competent learners experience feelings of success and failure. Dreyfus argues that in order to go beyond the competence stage, learners must move beyond the safety of rules (Dreyfus and Dreyfus 1986).

Proficiency: The competent learner becomes more emotionally involved. Consequently, the learner develops through positive and negative experiences. At this stage, the learner is able to identify goals and salient aspects, but not how these goals may be achieved. Therefore, the proficient performer is able to identify what needs to be done, but relies on rules to decide what to do (Dreyfus and Dreyfus 1986).

Expertise: Experts are able to identify what needs to be achieved, and can see immediately how these goals may be achieved. Due to vast amount of experiences, the expert is able to recognize situations that require particular responses. This immediate response is based on intuition and is characteristic of expert practice. Dreyfus argues that experts do not think, calculate responses or solve problems. They '*do what normally works*' (Dreyfus and Dreyfus 1986, p30).

To summarise, expert practice appears to develop over time, being facilitated through situational experiences which the learner encounters and reflects on in order to draw upon when making decisions.

3.4 Patricia Benner; From novice to expert

Based on the model proposed by Dreyfus (1986), Benner carried out a study involving interviewing nurses at different stages of practice from novice to expert in order to

'understand the differences in clinical performance and situational appraisal of beginning and expert nurses' (Benner 2001 p14). Findings of this study validated the Dreyfus model for nursing practice. According to Benner (2001), at novice level practitioners *'do not have any experience of the situations in which they are expected to perform' (Benner 2001, p20),* and therefore rely on rules to guide decisions or performance. Benner refers to nursing students as novices as they *'have little understanding of the contextual meaning of the recently learned textbook terms'* (p21).

The advanced beginner has experienced enough encounters or experiences in order to be able to recognise important aspects of the situation and recurrent patterns. However, Benner suggests that advanced beginners are unable to identify or perform clinical tasks in order of priority; *'their nursing care needs to be backed up by nurses who have reached at least the competent level..., to ensure that important patient needs do not go unattended because the advanced beginner cannot yet sort out what is most important'* (Benner 2001, p25).

Benner suggests that practitioners become competent usually after two to three years, if they encounter the same or similar experiences. The competent nurse identifies long term goals or plans for the client using analytical skills to assess the clinical situation. Benner suggests that the increasing organisation of nursing care is evident in competent practitioners; 'the *conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation'* (Benner 2001, p27).

Proficient nurses see the situation as a whole rather than in parts and is achieved through continued clinical experience, usually three to five years (Benner 2001). Proficient nurses learn from these experiences and modify plans to meet individual situations. Benner suggests that decision making becomes more refined; *'the proficient performer considers fewer options and hones in on an accurate region of the problem'* (Benner 2001, p29).

Finally, at the expert level the expert performer does not rely on analytic rules to guide decision making. Benner suggests that experts make accurate immediate judgments based on extensive knowledge, experience, and intuition. It is this

immediacy of decision making which distinguishes the expert from other levels of skill acquisition.

Expert practitioners are suggested to demonstrate expertise in the following domains; the helping role, the teaching or coaching function, the diagnostic and monitoring function, effective management of rapidly changing situations, administration of monitoring therapeutic interventions and regimes, monitoring and ensuring the quality of health care practices, and organization of work-role competencies (Benner 2001). The helping role includes providing emotional support, creating a climate committed to healing, encouraging and maximising patients' participation in their care, providing comfort through providing presence, touch and communication (Benner 2001). The teaching-coaching function role is based on the ability to assist patients to understand, cope with, accept and regain control over their illness (Benner 2001). The diagnostic and monitoring function is facilitated through the ability to anticipate, understand and detect problems. Effective management of rapidly changing situations includes skilled performance in extreme life threatening emergencies, being able to *'manage as well as prevent crisis'* (Benner 2001, p119). Monitoring and ensuring the quality of health care practices is essential to ensure that both safety standards are met, while patient needs are also met. This requires effective communication between nurses and medical personnel (Benner 2001). The final competency relates to organization and work role and is facilitated through coordination, teamwork, and meeting patients' needs (Benner 2001).

To summarize, Benner proposes that the transition from novice to expert is evident as practitioners become less reliant upon rules and analytical thinking to inform decision making, and instead use their wealth of clinical experience, knowledge and intuition to guide their choices. Competency or expertise has been identified in domains of practice as described above.

To add strength to the findings, Benner and colleagues have conducted extensive research on the concept of expertise and the five stage model of skill acquisition (Benner et al 1996). However, critics of this model argue that it is impossible to identify which stage nurses belong; if indeed they can be clearly separated into such defined broad terms (English 1993; Farington 1993; Edwards 1998). Consequently,

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there have been many attempts to define expertise and expert practice in various nursing disciplines (Jasper 1994; Paul & Heaslip 1995; Edwards 1998; Christensen & Hewitt-Taylor 2006a; Christensen & Hewitt-Taylor 2006b; Ericsson et al 2007).

3.5 Phenomenological and Cognitive Psychology perspectives of expertise

In 1994, Jasper undertook a concept analysis of the term expert in an attempt to clarify its meaning. Despite extensive exploration, Jasper concluded that *'it is apparent from this analysis and subsequent discussion that the term is ambiguous and difficult to clarify'* (p775). In an exploratory study to explore A&E nurses' constructs of the meaning of expertise, Edwards (1998) concluded that there appear to be two contrasting epistemologies of expert practice; the phenomenological and the cognitive psychology perspectives.

The phenomenological perspective derives fundamentally from the work of Benner (1984). Taking this perspective, Hardy et al (2002) defined expertise as *'an ability to use multiple forms of knowledge and self, in an apparently seamless way...providing and producing care that is tailor-made for the patient to promote positive change whilst also continuing to enhance the healthcare experience'* (p201). Paul and Healsip (1995) explored the relationship between critical thinking, expertise and intuitive practice and suggested that expert nurses practice *'intuitively by virtue of having developed, through critical thought a deeply grounded knowledge base that can be applied in daily practice'* (p40). In a more recent paper, Christensen & Hewitt-Taylor (2006b) define expert nursing practice as the ability to provide individualized holistic care, based fundamentally on intuitive decision making.

In contrast, the cognitive psychology perspective focuses on the behavior and logical decision making abilities of the expert (Jasper 1994). There has been much research into cognitive theories of expertise in engineering or computer based environments (Patel et al 2000). This perspective focuses on *'what goes on in the head of each learner'* (Bolander et al 2006, p42). Based on this perspective, Ericsson (2007) proposed a framework for expert performance and suggests; *'the expert performance approach offers a completely different theoretical framework for describing expertise in terms of measurable, reproducible performance that differs from the traditional views of expertise based on intuition and automaticity'*. (pE60). However, Edwards

(1998) contends that this perspective may be inappropriate to nursing due to the *'complex world of nursing practice... where the goals of care are often multiple and ill defined'* (p19).

It may be argued that the cognitive psychology perspective fits within the paradigm of medical expertise. Barton (2000) suggests that *'medical expertise is generally defined not only in terms of a body of specialized knowledge, but also in terms of its power and authority within social and cultural structures'* (p261). In their exploration of the theories of expertise, Eraut and DuBoulay (1999) propose that medical experts use clinical reasoning strategies to make decisions. These strategies are based on the ability to organize, store and retrieve information, and to solve problems or make decisions based on pattern recognition, and through categorization of knowledge (Eraut & DuBoulay 1999). Expert diagnostic problem solving processes are measured by their thoroughness, efficiency, quality of problem solving strategies, number of hypotheses taken into consideration, and the use of critical cues (Custers et al 1996). According to Bolander and colleagues (2006), medical experts recall facts to solve problems, processing signs and symptoms as integrated concepts. These expert knowledge structures are referred to as illness scripts (Bolander et al 2006). Illness scripts may be defined as *'precompiled packages of diagnostic and clinical knowledge describing a general source of events that may be expected to occur when someone suffers from a particular disease'* (Custers et al 1996, p385). Thus, expertise appears to be founded on the ability to recognize solutions from a well organized knowledge base (Patel et al 2000).

To summarise, both the phenomenological and cognitive psychology perspectives of expert practice appear to be fundamentally based on the integration of knowledge and experience. However, the difference between the two approaches appears to be the way knowledge and experiences are integrated into decision making. Where the phenomenological perspective places emphasis on intuition and critical reflection and views the situation holistically, the cognitive psychology perspective appears to be founded on the ability to recall chunks of information, using diagnostic reasoning techniques to solve problems. Thus, taking a phenomenological perspective, expertise is considered the ability to provide holistic care, rather than the ability to proficiently conduct a series of tasks (Christensen & Hewitt-Taylor 2006a). Another

difference between the two perspectives appears to be the ability to measure or quantify expert practice. Christensen & Hewitt-Taylor (2006b) suggest that *'successful cure is easier to demonstrate in measurable terms than care'* (pg1536). Therefore, an expert surgeon may be measured by their success or failure of a particular operation, or by mortality rates (Christensen & Hewitt-Taylor 2006b). However, they acknowledge that nursing involves many caring aspects that cannot be quantified.

It may be assumed that intrapartum maternity care expertise would follow the phenomenological epistemology proposed by Benner (1984). Although midwifery may have similarities with nursing practice, there are subtle differences. Where nursing deals with illness and disease, maternity care encompasses on the whole a normal life event. The following section presents a summary of expertise in the context of maternity care.

3.6 Expert intrapartum maternity care: presenting the evidence

This section presents a summary of the findings of a recently published review in this area, undertaken by the author in collaboration with two colleagues [6] (Downe et al 2007). Please refer to appendix 1 (pg 152) for a full copy of the published review.

3.6a Aim

To explore the accounts of intrapartum midwifery skills, practices, philosophies and beliefs given by practitioners working in the field of intrapartum maternity care who are deemed to be 'expert' or 'practising beyond the ordinary'.

3.6b Background

As explored above, expertise in nursing and medicine has been subject to much exploration and debate with various models for developing expertise proposed (Dreyfus & Dreyfus 1986; Custers et al 1996; Benner et al 1996; Price & Price 1997; Benner 2001; Eraut & Du Boulay 2001). However, there appear to be a limited

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[6] SD (Soo Downe), LS (Louise Simpson- author of thesis), KT (Katriona Trafford). SD was responsible for the study conception and design. SD, LS, and KT were responsible for drafting the manuscripts. LS and KT performed the data collection. SD, LS, and KT performed the data analysis. LS obtained funding. SD supervised the study.

number of studies relating to expertise in the context of maternity care. Despite a recent publication describing the attributes of a 'good' midwife (Nicholls & Webb 2006), there do not appear to be any agreed characteristics for non-medical experts in maternity care.

3.6c Method

The aim of the review was to include all non-medical practitioners working in the field of intrapartum care, rather than focus specifically on those practitioners bearing the official title 'midwife'. This was based on the assumption that the definition and significance of the term 'midwife' with regards to education, professional status, legislation or training, may not be appropriate to those practitioners working in other parts of the world. The terms qualified midwife, midwifery student, nurse, nurse-midwife, lay midwife, traditional birth attendant, patera, dai, and doula were included in the review in order to capture those professionals providing intrapartum care in countries across the world. The terms expert, exemplary, excellent and experienced were used to capture those practitioners practising beyond the ordinary.

The systematic review included twelve databases and fifty relevant journals. These were searched electronically or by hand using defined search terms, inclusion and exclusion criteria (see appendix 1 pg 152). Papers selected were published between January 1970 and June 2006 and in the English language. The reviewing process was iterative, involving all three members of the research team. Included papers were subject to quality review using the Critical Appraisal Skills Programme Criteria (CASP 2002).

There were seven papers included in the review (See appendix one, p152). Five of the papers included qualified and licensed midwives, and two included labour ward nurses. Five of the studies were undertaken in the USA (Sleutel 2000; Kennedy 2000; Kennedy 2002; James et al 2003; Kennedy 2004). Although three of the papers were conducted by the same author, each paper reports a different study. The remaining two studies were conducted in Sweden (Berg & Dahlberg 2001; Lundgren & Dahlberg 2002). Although both papers have the same second author, both papers reported different studies.

3.6d Findings

Thirteen codes were initially identified from the data. These codes included education; experience; knowledge; competence; confidence; judgement; skills; trust; intuition; connection; companionship; role changes and profession. Iterative reflection between the codes and original data led to the identification of three overarching core themes, and one parallel theme:

1. Wisdom
2. Skilled practice
3. Enacted vocation
4. (Parallel theme) Reaction to the context of childbirth

A summary of each theme will now be presented.

3.6e Wisdom: Knowledge through education, training and experience

The types of knowledge and experience expressed in the papers, suggested that expertise was more than intellectual knowledge gained through book learning or education, or about the same years of experience repeated over time. Expertise was suggested to develop as a result of continuously updating knowledge through reflection and personal peer review, incorporating both experiential and formal education into ongoing knowledge development. In Kennedy's first study (2000), the exemplary midwife was suggested to possess *'a maturity and wisdom that is not necessarily related to age, and which supports her knowledge of birth' (p9)*. Reflection on this led to the consideration of the concept 'wisdom'.

For many, the concept of wisdom has connotations of age, and of experiential and not necessarily intellectual or academic learning. The following quote represents what is perceived by the term;

'Wisdom is a state of the human mind characterised by profound understanding and deep insight. It is often, but not necessarily, accompanied by extensive formal knowledge. Unschooled people can acquire wisdom, and wise people can be found among carpenters, fishermen or housewives. Wherever it exists, wisdom shows itself as a perception of the relativity and relationships among things. It is an awareness of

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wholeness that does not lose sight of particularity or concreteness, or of the intricacies of interrelationships' (Meeker 1981)

3.6f Skilled Practice: demonstrating reflexive competence; confidence; judgement and skills

Skilled practice appeared to be made up of four components; reflexive competence, confidence, judgement and the capacity to use technical and fundamental midwifery skills. Emphasis was placed on both clinical and technical skills in all the papers considered in the review. The subtle and complex skills that were performed to keep birth normal included hands-on high touch techniques, the ability to facilitate or 'orchestrate' the birthing environment (Kennedy 2002), and the use of the 'sensitive knowledge' noted by Berg & Dahlberg (2001). These skills were evident in both the care of low-risk and high-risk women.

Kennedy (2000) noted that midwives in her study demonstrated exceptional clinical skills when it became necessary to intervene. James and colleagues (2003) identified the importance of the technological and complex nursing skills of their participants. However, it appeared to be more than simply an issue of being competent in these fundamental skills, or in responding to emergency situations. These professionals also appeared to demonstrate the ability to foresee likely events in both the labouring woman and the surrounding environment. Midwives worked with these predictions in order to optimise the birth outcomes for women.

The use of the term 'reflexive competence' was intended to express the nature of the accounts of competence in the papers included in the review. It refers to a skill that did not appear to be constantly on show (Kennedy 2002). The midwife remained in the background, using her skills only when her expertise was needed. This suggested a competence which was so well embedded that it did not require the midwife to be in control of the labour. Experts were suggested to be able to navigate through the rapid changes or uncertainties of labour, and were not dependant upon standard guidelines or protocols, or routine practices. It allowed for practitioners to facilitate optimal situations, and to prevent adverse events before they occurred.

The terms competence and confidence appeared to be inter-related in this review. Kennedy (2000) noted a somewhat different interpretation of the term confidence, and suggested *'the midwives demonstrated the confidence not to act in situations to promote the normalcy of birth. This was termed 'the art of doing nothing well' (p12).* Rather than an ability to take decisive clinical action, this phrase conveys a different type of ability, based on the confidence not to act. Where practitioners in the included studies were free to make judgements on the basis of labour itself, aside from external pressures, they appeared to transcend from 'waiting for the woman' (Lundgren & Dahlberg 2002) at one end of the spectrum, to 'seizing the woman' at the other. The expertise appeared to derive from the practitioner's ability to navigate through, or find balance between these two extremes.

3.6g Enacted Vocation: Placing value on belief, courage, trust, intuition, and connected relationships.

Expert practitioners in this review appeared to express qualities such as trust, belief and courage, made intuitive decisions, and valued connected relationships with women. These experts had a profound understanding and trust in the normal birth process, which led to them challenging the boundaries and practices within normal childbirth.

Values such as belief, trust and courage appeared to be prominent in the included studies. Phrases such as *'following the mother's body'* (Sleutel 2000), *'belief in women's bodies'* (James et al 2003), and *'belief that the woman's body was capable'* (Lundgren & Dahlberg 2002) supports both the belief in women's capacity to give birth, and the belief in the physiological processes of childbirth. Trust and belief appeared to transcend from midwife to woman, building a virtuous circle of trust and belief. Courage appeared to be represented by the practitioner's ability and need to stand up for their beliefs, and the beliefs of the women. This courageous stance in everyday decision-making appeared to result from a deep-rooted trust and belief in women's ability to give birth, and in the process of physiological birth.

Kennedy (2000) noted that exemplary midwives in her study *'practiced with skill, experience and an uncanny knowing of when to step in and when to let me be' (p9).*

This capacity to act intuitively is also evident in other studies in the review (Berg & Dahlberg 2001; Lundgren & Dahlberg 2002; James et al 2003). Lundgren & Dahlberg (2002) note the more intensive the relationship with the woman, the more intuitive the midwife becomes.

Being 'present' for the woman during the birth process, but not 'doing' anything physical to her was suggested a fundamental component of expert midwifery practice (Kennedy 2000, Kennedy 2002; Kennedy 2004). The term 'presence' was used to describe something more than just being present in the room. It relates to the midwives' ability to guide and encourage, creating an unobtrusive environment of safety and calm (Anderson 2000).

Berg and Dahlberg (2001) described an 'enduring presence', which included *'nearness, both in an emotional and physical sense' (p262)*. Sleutel (2000) described it as supportive, nurturing and empowering. Both James and colleagues (2003) and Berg and Dahlberg (2001) talk of practitioners 'being attuned', while Lundgren and Dahlberg (2002) described the midwife being an 'anchored companion'. The concept of companionship is accompanied by qualities such as openness, listening, respect, warmth, sensitivity, nurturing, and other qualities that express a relationship of profound caring (Downe et al 2007). In order for this connection to occur, the midwife must know and understand the woman (Kennedy 2000), and work in partnership with her through the birth process (Lundgren & Dahlberg 2002).

3.6h Parallel theme: Reaction to the context of childbirth

This concept incorporates role changes, professional conflict and 'ironic intervention' and has been addressed separately as it appears to represent the way expert practice is moderated, distorted or influenced, rather than the fundamental concept of expertise. This theme most strongly emerged during Sleutels' (2000) study; *'intrapartum nursing care reflected both a medical model of controlling and hastening birth, as well as a supportive, nurturing model' (p38)*. This led to practitioners using interventions they did not usually support in order to reduce the risk of caesarean section. Similar findings were evident in Annandale's study (1988). Although the study was not included in the review, the term 'ironic intervention' was used by Annandale to describe the use of interventions in order to avoid further (more

invasive) interventions. This appeared to resonate with the findings of the review. We therefore borrowed the term 'ironic intervention' to describe this theme.

This practice led to dissonance for the practitioners, and a lack of ability for them to justify their initial interventions to women. There is a concern that this practice may disrupt the virtuous circle of trust and belief between the midwife and the woman, with the decreased potential for physiological birth.

3.7 Summary

There appear to be two fundamental epistemological positions underpinning expert practice. The cognitive psychology perspective appears to fit with the medical paradigm. It is characterised by the ability to analytically solve problems, and cure or treat disease. In contrast, the phenomenological perspective considers more subtle aspects such as intuitive decision making based on knowledge and experience. Care is holistic, and decisions take into consideration long term health goals.

Intrapartum maternity care expertise appears to be founded on the ability to reflect on and integrate knowledge gained through experience, and to provide holistic care to women, babies and their families. Expert maternity care practitioners demonstrate confidence, competence and skill in fundamental and technical skills, value connected relationships with women, and build relationships founded on honesty and trust. Care is holistic, encompassing the situation as a whole. Decision making is immediate, and often intuitive, founded on the integration of knowledge and experience. Many of these findings resonate with the phenomenological paradigm of expertise proposed by Benner (1984).

It appears that practitioners who are practising 'beyond the ordinary' may demonstrate specific skills, attitudes or beliefs that make them unique at what they do. The concepts of wisdom, skilled practice and enacted vocation may provide a useful framework for understanding this. However, the review raises questions about how experts practising 'beyond the ordinary' accommodate the conflict between different philosophies of care. Evidence suggests that many midwives and nurses are practising in labour environments influenced by medical models or technocratic models of care (Crabtree 2004; Mead 2004; El-Nemer et al 2005). It is therefore

important to understand how these practitioners accommodate dissonance between the contrasting models of care. In order for knowledge and practice to develop, it is imperative that expert practitioners are identified in order to expand the scope of practice and boundaries of care (Jasper 1994). This is the rationale for the current study.

4.0 Theoretical perspectives chapter

4.1 Introduction

'Theories within the social and psychological sciences continue to shape practice' (Houston 2001, p845). It may be argued to be imperative that the researcher fully understands the philosophical and theoretical assumptions underpinning their research (Caelli 2001). This requires the researcher to understand the implications of concepts such as paradigm, epistemology, ontology and theoretical perspective, and how these inform the methodology and method adopted for any specific study (Dykes 2004).

The aim of this chapter is not to give an in-depth exploration of theoretical or philosophical frameworks, but to identify and give a brief account of how philosophy and theory have influenced and informed the research process. The structure of the chapter will be based on the work of Crotty (1998) and will be subdivided into four concepts: epistemology, theoretical perspective, methodology and methods. Within each concept, links will be made to current midwifery practice, and the context of the research question.

4.2 Epistemology

Epistemology may be defined as the study of the nature of knowledge (Cluett & Buff 2000). Wainwright (1997) argues that knowing is dependent upon three concepts; ontology (what exists); epistemology (how we come to know), and methodology (how we acquire knowledge). He also argues that these three concepts *'contribute to the philosophy of a paradigm'* (p1263). Kuhn (1970) suggests that a paradigm refers to different ways of 'seeing the world'. This is influenced by beliefs and values. Crotty (1998) identifies three epistemological positions: objectivism, constructionism and subjectivism, each being grounded in their own specific paradigm.

4.3 Rationale for taking a constructionist perspective

Superficially, it may be presumed that philosophy and midwifery have little in common. However, Socrates (who incidentally was the son of a midwife) claimed *'to have modelled his method of philosophical enquiry on his mothers work...Socrates*

used midwifery as a metaphor to describe both the route towards true knowledge and the role of the philosopher in helping others reach it' (Parker & Gribbs 1998, p146).

Midwifery may be argued to be a profession which has been influenced by culture and tradition. Beniot et al (2005) suggest; *'the social location of midwifery reveals a societies fundamental cultural ideas about women as (1) autonomous (or not) professionals in the maternity division of labour as (2) legitimate (or not) recipients of midwifery care services across the childbearing period'* (p723).

My prior beliefs were that individual midwives' experiences and perceptions would be influenced by external factors such as prior experiences or workplace culture. This lends itself to a situation where multiple 'truths' will exist, as experiences and perceptions will be subjective. This appears to fit with the constructionist standpoint (Crotty 1998). Dykes (2004) has argued that *'constructionism emerged as a critique of the objectivist epistemology'* (p19). From a constructionist viewpoint, Crotty (1998) argues that the social world is created through human interaction. Thus, meanings are not uncovered or created, but are socially constructed. The task of constructionism is not to grasp objective meaning, but to emphasise that human understanding is a construction and interpretation (Barkway 2001). Thus, as individual interpretations are subjective to external and internal influences, constructionists reject the notion of 'truth', recognising that multiple realities exist (Crotty 1998).

4.4 Theoretical perspective

The term 'theoretical perspective' refers to the theoretical stance informing the methodology of a research study (Crotty 1998). There are a vast number of theoretical perspectives including positivism, post-positivism, interpretivism, critical inquiry, and feminism (Crotty 1998), with roots in two distinct paradigms namely positivism and interpretivism (Cluett & Bluff 2000, Mottier 2005).

Positivist approaches are underpinned by an ontology that 'truth' exists, with knowledge generation requiring deductive methodology and scientific methods (Chalmers 1976; Wainwright 1997). Thus, positivism takes a research perspective that strives to be scientific (Cluett & Bluff 2000). However, some philosophers have

argued this perspective is inappropriate to the human and natural sciences, as it does not allow for the subjective uniqueness of the human world (McPhail 1995).

The terms positivism and interpretivism are often used interchangeably with the terms quantitative and qualitative research respectively (Williams 2000). There is much debate about the nature and application of quantitative and qualitative research methodologies in health care research.

In brief, quantitative research tends to place emphasis on reliability and validity, with large numbers of participants being recruited in an attempt to minimise bias (Rees 1997). This approach focuses primarily on statistics and statistical methods of analysis, where cause and effect hypotheses can be tested (Silverman 2000; Kennedy 2001).

In contrast, qualitative research may be defined as '*multi method in focus, involving an interpretive, naturalistic approach to its subject matter.... Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them*' (Denzin & Lincoln 1998, p3). Qualitative research is interpretive and reflexive, capturing the voices or experiences of both the participant and the researcher. It allows exploration of issues that were previously inaccessible using traditional scientific, quantitative methods (Caelli 2001). Emphasis is placed on the depth and richness of the data obtained, rather than the number of participants included in the study (Rees 1997).

4.5 Theoretical perspective: Rationale for taking an interpretive perspective

Interpretivism directly contrasts that of positivism and post-positivist perspectives, in that subjectivity is regarded a crucial, positive component of the research process (Mottier 2005). Interpretivism focuses on human beings and the way in which they interpret their world (Holloway (Ed.) 2005). Crotty (1998) postulates that interpretivism looks for '*culturally derived and historically situated interpretations of the social-life world*' (p67). Taking an interpretive standpoint, it is acknowledged that society and culture have constructed and influenced the nature, scope and meaning of midwifery. Thus, the focus for this study is on how individuals construct meanings,

and how these meanings are influenced by our every day world (Silverman 1998; Darbyshire et al 1999).

4.6 Methodology

Methodology provides an interpretation and theoretical understanding of the social world and people in the world (Maggs-Rapport 2001). Methodology refers to the philosophical framework that must be acknowledged, to enable to researcher to consider the assumptions of that particular approach (Caelli 2001). Through the application of a methodological perspective; *'it is possible to gain an understanding of the subjects who are being researched and explain and interpret the meaning they place on events in their lives and the experiences they have'* (Halkett et al 2004, p8).

Dykes (2004) argues the methodology must be appropriate to the research aims and be consistent with the researchers theoretical perspective. There is a range of methodological perspectives each fitting within the overarching paradigms of qualitative and quantitative research (Crotty 1998). Failure to justify the methodology employed may be argued to affect the integrity of the research (Baker et al 1992; Watson 2004).

4.7 Methodology: Rationale for taking an interpretive / hermeneutic phenomenological perspective

The aim of the research was to explore midwives 'lived experiences' of the nature of midwifery expertise in the context of intrapartum care. Therefore, an interpretive phenomenological perspective was appropriate to the study. It is acknowledged that the research could have been conducted using a different approach. However it may be argued that it was more appropriate to first uncover the meaning of expertise from the perspectives of midwives using a phenomenological approach, before trying to apply methods of observing it in practice, such as ethnography.

Phenomenology is a philosophical movement, which stands in contrast to the positivist paradigm as it recognizes the importance of the subjective nature of experience, and does not intend that verifiable knowledge will result from the research process (Mc Phall 1995). Phenomenology *'is the systematic attempt to uncover and describe the structures, the internal meaning structures, of the lived*

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experience...' (Van Manen 1990, p10). In other words, the aim of phenomenological research is to gain a deeper understanding of the 'lived experiences' or the nature or meaning of everyday experiences from the perspectives of the research participant (Van Manen 1990). Broadly there are two opposing schools of thought about the fundamental concepts of phenomenology (Husserlian and Heideggerian), each with distinctive differences affecting the methodology employed (Koch 1995; Dykes 2004).

Phenomenology was developed by Husserl at the beginning of the 20th century (Baker et al 1992). Husserl retained elements of objectivity in his phenomenological perspective valuing positivistic epistemology (Walters 1995; Lopez & Willis 2004). Husserl argued that objectivity could be achieved through the process of bracketing personal knowledge and experience from the research process (Lopez & Willis 2004). This requires the researcher to 'bracket' prior knowledge or perceptions to prevent them from influencing the data (Crotty 1998).

Lopez and colleagues (2004) argue that *'the impact of culture, society and politics on the individuals' freedom to choose are not central to Husserl's thought'* (p728). The phenomenological method developed by Heidegger contrasts to that of Husserl, in that Heidegger argues it impossible to bracket or suspend prior beliefs from research (Walters 1995).

The terms 'interpretive phenomenology' or 'hermeneutic phenomenology' may be used to describe the phenomenological approach underpinned by Heideggerian principles (Cohen & Omery 1994). Taking a hermeneutic or interpretive phenomenological perspective, value is placed on the perspectives and prior beliefs of the participants and researcher (Walters 1995), with emphasis being placed on the social and historical context of the experience (Draucker 1999). Phenomenology aims to explore how people understand and interpret their own world (Steeves et al 2000). In order to achieve this, it is important to explore both the whole lived experience and the individual aspects of the experience (Cohen 2000). Emphasis is placed on how social, cultural and political factors, and prior experiences influence the choices people make (Lopez & Willis 2004).

I believe that these subjective experiences of both the participant and the researcher are regarded as essential elements of the research process and are examined and explicated, rather than suspended (Draucker 1999). An example of this is given on page 52 in the reflectivity chapter.

From a Heideggerian perspective, the process of bracketing or phenomenological reduction becomes inappropriate to the nature of the study as external factors such as prior experiences and culture influence individual perceptions, and shape cultural perceptions of the nature of midwifery, normal birth, and expert practice. Thus, meanings cannot be separated from their historical or cultural contexts.

4.8 Methods

Caelli (2001) suggests the terms 'methodology' and 'method', have distinct differences, especially within the context of phenomenological research. As discussed, methodology refers to the philosophical analysis of fundamental research, whereas method refers to the techniques used to gather the data (Wainwright 1997). The method selected must be congruent with the philosophical assumptions underpinning the methodology (Koch 1995; Watson 2004).

Halkett et al (2004) argue the main data collection methods within qualitative research include in-depth interviews, focus groups, and observations. McPhall (1995) suggests phenomenological methods can be judged by their usefulness in exploring the nature of the 'lived experience', and in their appropriateness to address the research question, and rationale for the research.

The two methods employed within this study are group interviews and individual interviews. Both methods, and their justification for use, will be explored separately.

4.9 Justification of use of chosen method

4.9a Group interviews: Definition

The terms 'group interview', 'group discussion' and 'focus group' appear to be used interchangeably in the literature, and often used to describe the same phenomena (Hughes & Dumont 1993; Coreil 1995; Kitzinger 1995; Sim 1998; Morgan 1998; Krueger 1998; MacTavish et al 2000). However, there appears to be much debate in the literature surrounding these definitions, and whether in fact they can be used to

represent the same phenomena (Morgan and Spandish 1984; Merton 1987; Bers 1989; Stewart and Shamdansi 1990; Morgan 1996; Krueger 1998b; Barbour 2005; Woodring et al 2006).

Despite the lack of clarity in the proposed definitions of focus groups and group interviews, there appear to be common elements evident in the two approaches with regards to their purpose, and how they are conducted. Robinson (1999) postulates that the prime objective for both is the ability to obtain rich accurate data on a range of specific issues within a social context. Wilson (1997) suggests that focus groups or group interviews include a small group of 4-12 people, who meet with a trained researcher/moderator, in an interview lasting 1-2 hours, discussing selected topics, in a non-threatening environment, exploring participant perceptions, attitudes, feelings, ideas and encouraging and utilising group interaction.

It is evident in the literature that the fundamental difference between group interviews and focus groups appears to be the significance placed on 'group interaction' (Morgan 1996). Wilson (1997) agrees that group interaction is an integral part of the focus group research process, being the most significant criterion distinguishing it from group interviews.

The definition used as a basis for this method is that proposed by Morgan (1996): *'Group interviews are something other than focus groups if they; are conducted in informal settings; use non-directive interviewing; or use unstructured question formats'* (p131).

Group interviews: Justification of use:
The primary aim of the research was to discover and explore individual meanings of the phenomenon of midwifery expertise, and identify how these perspectives may be influenced by a group context. In a group situation, it becomes possible to identify and explore conflicting ideologies of intrapartum expertise (through use of words) and also uncover how individual meanings are constructed. In this context, group interviews provide information on the dynamics of attitudes and opinion (Morgan 1998), and allow the different perspectives of groups of individuals to be observed (Rabiee 2004). There are many differing perspectives and approaches to

phenomenological and hermeneutic research (Crotty 1996; Flemming et al 2003). However it is acknowledged that there is debate in the literature surrounding the compatibility of focus groups or group interviews within the phenomenological framework (Calder 1977; Wilkinson 1998; Webb & Kevern 2001; McLafferty 2003). Webb & Kevern (2001) argue *'a phenomenological approach requires that an individual describes their experiences in a relatively 'uncontaminated' way and therefore a group method of data collection involving interaction between several participants is not compatible with phenomenological research'* (p800).

In contrast, Priest (2002) postulates that a wide variety of approaches may be employed under the phenomenological framework, including group discussions, written accounts or diaries. Calder (1977) suggests that focus groups or group interviews can be phenomenological in that they explore conceptions and explanations.

Kitzinger (1995) argues that the group process allows participants to clarify and explore their views more effectively than in an individual interview. Robinson (1999) suggests group interviews enable *'complex dimensions to be revealed' (p906),* allowing aspects of culture and society to be explored. Group interviews provide 'neutral controls on data collection' as participants challenge or question extreme viewpoints (Robinson 1999), validate information given by others, and allow the moderator to probe for deeper levels of information (Lane 2001). Thus the group interview method is argued to have high face validity (Nyamathi 1990).

Another benefit of the group interview method is that there is an increased range of data collection in a short time period (Lankshear 1993; Reed and Payton 1997; Robinson 1999) A study conducted by Fern (1982) which directly compared both focus group and interview methods, revealed that each focus group participant only produced 60-70% as many ideas as he or she would have produced during an individual interview. However, results of the study suggest that two eight person focus groups would produce as many ideas as ten individual interviews. Thus, group interviews are an effective method in being able to obtain a large number of views and opinions on relatively under-researched topics, or to provide a framework for use in further studies.

However, the 'depth' or 'richness' of the data resulting from group interviews may be argued to be inferior to that of individual interviews, as collective rather than individual meanings of the phenomena are obtained (Sim 1998). Thus, follow up in-depth individual interviews were employed as the secondary method of data collection.

4.9b Individual interviews: Definition

From a philosophical and epistemological perspective, qualitative interviews allow the researcher to access participants' understanding of the world and their experiences (Taylor 2005). Interviews can be structured, semi-structured, or unstructured (Myers & Newman 2007). A structured interview is defined by the restrictive interview schedule. Semi-structured and unstructured interviews are characterised by an incomplete script, and are thus open to improvisation during the research interview (Myers & Newman 2007). The phenomenological interview enables the researcher to capture, in the respondents own words, their lived experiences. The purpose is not to explain, predict or generate theory, but to draw from respondents a vivid picture of the lived experience, exploring the context that shapes the experience (Sorrell & Redmund 1995). The interview often begins with an opening question (i.e., tell me about you experiences of...), allowing the participant to share a narrative which reveals thick descriptions relating to their personal encounter with the phenomenon (Sorrell & Redmond 1995). Thus, the participants' story shapes the interview.

The hermeneutic phenomenological approach incorporates both the views of the researcher and the participants (Rapport 2005), and thus does not necessitate researchers to bracket or suspend their own prior beliefs or experiences (Lowes & Prowse 2001; Taylor 2005). This allows for meanings to be co-created by researcher and participant (Lowes & Prowse 2001).

Individual interviews: Justification for use

Interviews may be argued the most appropriate primary method of data collection in phenomenological research (Taylor 2005). However, the justification of use of group interviews as the primary method of data collection has been previously addressed, allowing for the social context of the phenomenon to be uncovered and explored. The aim of the follow-up interviews was therefore to explore individual meanings or

stories. This pool of knowledge would then be tapped in to, in order to add depth and richness to the group-interview data and explore individual experiences of the phenomenon.

4.10 Summary

The research question for this study is fundamentally based on a constructionist epistemology, underpinned by the interpretive paradigm, adopting a qualitative, phenomenological methodology. It appears that the combination of the two methods (group interviews and individual interviews) are appropriate to the underlying philosophical and theoretical framework and also in addressing the research question proposed, allowing for individual meanings of expertise to be explored in a social context. The following chapter will address issues surrounding the research method employed, and the research process.

5.0 Methods chapter

5.1 Introduction

The aim of this chapter is to address issues surrounding the data collection process. Theoretical background information will be given for each section, followed by a detailed account of how the research was conducted.

5.2 Planning

Within the group or individual interview method, the interview guide or schedule plays an important role in ensuring that appropriate data are collected (Thackemay & Neiger 2004). The interview guide used in this research was based on previous literature surrounding the phenomenon including the systematic review discussed in chapter three (page 14), and was loosely structured to allow a wide range of spontaneous views and accounts to be captured. The group interview guide consisted of three research areas that were to be addressed during the group interview (midwifery expertise in general, normal birth, and expertise in normality). Under each section, prompts were listed to guide the discussion if required. The interview guide acted as a standard starting point for all four group interviews (see appendix 2 page 153). This interview guide reflects the initial focus of the study on experts in normal childbirth. However, during the process of the group interviews, the importance of a wider focus became apparent. Thus, the interview guide used during the individual interviews consisted of one open ended question, to facilitate the participant's spontaneous accounts of their experience of their encounter with expert practice. Two further questions were added to explore expertise in high risk and low risk environments. Please refer to appendix 3 (p154) for a copy of the individual interview guide.

5.3 Developing the research question

The research process started with three basic questions:

1. What skills, attitudes and beliefs do midwives believe are essential characteristics to determine expert practice

2. What are the essential characteristics and skills that facilitate optimal birth outcomes for women

3. How do midwives describe their encounter with expert midwives

The primary aim of the group interview method was to gain an in-depth understanding of the meanings midwives place on the phenomenon; 'nature of midwifery', 'normal birth', and 'expertise in childbirth', and explore these meanings in a social context. The primary aim of the individual interviews was to discover and explore individual midwives' understanding of, experiences, and meanings attributed to intrapartum expertise.

5.4 Sample

Patton (2002) suggests that sample size in qualitative research is dependent upon the purpose of the research, what would be useful and credible, and the amount of time and resources that are available. Qualitative research usually involves a small sample of participants which are studied in-depth (Miles & Huberman 1994). Thus, sampling in qualitative research tends to be purposive (Morse 1989; Todres 2005). Purposive sampling fits within the interpretive-phenomenological or hermeneutic-phenomenological perspective as it *'deliberately aims to ascertain theoretical insights into the cultural variables of the population and tends to generate rich data, which broadly reflects the population from which it is drawn'* (Lane et al 2001 p48). This method of sampling also fits within the framework for conducting group interviews and individual interviews (Morgan 1998b).

The method of sampling employed within this study therefore was purposive. Practising midwives (E-H grades[7]), located in the North-West of England, employed within two midwifery led units, and two consultant units, provided the sampling frame for this research. In order to capture a wide range of experiences and meanings, one consultant led unit had a higher than UK national average rate of normal birth (site a) (as defined by Birth Choice UK[8]), while the other had a lower

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[7] Prior to the implementation of a new grading system in 2006 (agenda for change), Practising midwives' were graded from E to H grade, with E grade midwives' regarded more junior and H grade usually managers. However, the grades were not necessarily determined by years of experience. Midwives' transcended through the grades via promotion.

[8] Birth choice UK www.birthchoiceuk.co.uk

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than UK average rate of normal birth (site b). Both midwifery led units were free standing[9] midwifery led units (sites c & d). The rationale for the inclusion of both midwifery led and consultant units was that they can be expected to cover a range of philosophical approaches to childbirth.

5.5 Site demographics

Site	Site demographics
SITE A	Approx 2000 births per year using 2002-2004 Birth choice UK data where available, proving care to low/ high risk women. Higher than UK average rate of normal birth[10].
SITE B	Approx 2500 births per year using 2002-2004 Birth choice UK data, providing care to low / high risk women. Lower than UK average rate of normal birth.
SITE C	Approx 230-250 births per year using 2002-2004 Birth choice UK data where available, Freestanding midwifery led unit caring for low risk women. Hospital transfer rate more than 20% (Using 1998 birth choice UK data).
SITE D	Approx 300 births per year using 2002-2004 Birth choice UK data where available, free-standing midwifery led unit caring for low risk women. Hospital transfer rate less than 20% (Using 1998 birth choice UK data).[11]

NB Exact figures have not been given as this would allow participating sites to be identified from the data.

A random selection of midwives from the sampling frame provided the study sample. Once ethical approval had been obtained, and permission given by each of the clinical sites R&D department, the Head of Midwifery at each participating site distributed research information packs to a random selection of participants using a random

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[9] Free standing midwifery led units are run by midwives' and provide care for low risk women. There are no obstetricians available on site. Women requiring obstetric intervention would require transfer to the nearest consultant unit.
[10] The UK average rate of normal birth for 2002(45%), 2003(47%), 2004(46.4%), 2005(48%)
[11] Transfer rates varied from 0%-31.1% using 1998 data

number table provided by the researcher. Although random sampling is not usually applied to qualitative research, this process allowed us to obtain a sample of midwives from different grades. The Head of Midwifery acted solely as a distributor of the information packs. Participants responded directly to the researcher once the initial information pack had been received. Only the research team had access to the names of participants consented in this study.

5.6 Data collection procedure
5.7 Ethical considerations

Ethical approval was sought and obtained from the local research ethics committee. Research and Development department approval was sought and obtained from each of the clinical sites. Managers or Heads of midwifery acted solely as distributors of the information packs to potential participants as to maintain the confidentiality of potential participants' details. Participants were informed that confidentiality would be guaranteed, no-one having access to the interview transcripts other than the research team. No names or other identifiers were used in the transcripts. Data, including tape recordings and coding sheets, were stored and will be destroyed in accordance with the requirements of the LRECs, the Data Protection Act, and Local Caldicott requirements.

5.8 Phase 1: Group-Interview method.

Conformity and compliance can be a problem in a group setting (Maguire 1998). Sim (1998) argues that the composition of the group may influence the extent of this conformity. Thus, homogenous groups (similar age, background, ethnic and social background) are generally recommended (Krueger 1994; Sim 1998). However, there is some debate as to whether pre-existing groups should be used when conducting group-interviews. Krueger (1994) argues that pre-existing power and leadership relationships may influence group dynamics. However in contrast, Kitzinger (1994) encourages the use of pre-existing relationships, as participants may be more comfortable relating to, or challenging each others' comments.

It was originally intended that two group interviews be conducted within each consultant led unit, separating the groups to E-F grades and G-H grades, to minimise

the impact of group hierarchy on the group dynamics. It was intended that only one group be conducted within each of the midwifery led units as the midwives employed in these units were of similar grade. This would necessitate 6 group interviews being conducted. Krueger (1994) suggests that group interviews should be repeated until theoretical saturation occurs (further groups yield no new data). Morgan (1996) suggests this is usually achieved in four to six groups.

The literature surrounding the optimal size of the group in the group interview method remains unclear, with group sizes suggested varying from 3-10 participants (Morgan 1998b). Krueger & Casey (2000) contend that the optimum number of participants taking part in a group interview may vary. They suggest the group must be large enough to gain a variety of perspectives, and small enough not to become too disorderly or fragmented. They therefore suggest an optimum number of 6-8 participants. Rabiee (2004) suggests researchers over-recruit by 10-25%, depending on the topic and group of participants. The recruitment procedure was therefore continued until at least ten consent forms for each group were returned, or when further recruitment attempts yielded no further returns. The justification for this number of participants was to allow for approx six participants in each group, as we ideally wanted a smaller group to enable more in-depth responses and individual stories or meanings to be heard.

Table 5b: Recruitment process

Site demographics	Response rate
Site a (Consultant unit with higher than UK average rate of normal birth)	60 information packs distributed, 10 consent forms received, 5 participants attended group interview
Site b (Consultant unit with lower than UK average rate of normal birth)	65 information packs distributed, 8 consent forms received, 5 participants attended the group interview
Site c (free-standing midwifery led unit; higher rate of transfer):	20 information packs distributed, 9 consent forms received, 3 participants attended the group interview
Site d (free standing midwifery led unit; lower rate of transfer)	20 information packs distributed, 11 consent forms received, 9 participants attended the group interview

Conducting the group interviews

Krueger (1994) believes that rich data are only obtained if the participants fully engage in the discussion. This can be facilitated through the use of a skilful moderator, who creates a trusting and comfortable environment (Rabiee 2004). Sim (1998) argues the skill of the moderator is crucial to the nature and quality of the data collected. One of the fundamental roles of the moderator is to be able to manage power relationships within the group, and to ensure that one participant does not dominate the discussion (Reed & Payton 1997). The literature supports the use of an assistant moderator during the discussion to take field notes, paying particular attention to group dynamics, and any significant non-verbal behaviour (Kidd & Parshall 2000; Rabiee 2004). Both the moderator and assistant moderator in this study were experienced in running group discussions and meetings within the clinical environment. Both moderators (LS & KT) facilitated the group interviews. LS was responsible for taking detailed field notes.

Group interviews were conducted between November 2004 and April 2005. Due to the low response rate, it was decided that one group interview be conducted in each of the clinical environments instead of two. This resulted in mixing all grades of staff in the group interviews. Participants were informed of this change prior to the interview and given the opportunity to drop out of the interview if required. The group interviews were conducted at a time and location specified by the participants. This was to ensure maximum participation. All group interviews were conducted within the participants' working environment. Rooms were private and comfortable, with light refreshments provided. Participants were contacted 3 days prior to the group interview to confirm attendance. Despite this, attendance rates varied within the sites. The main reason for non-attendance was due to staff shortages on the day of the interviews. This was most significantly observed in site C, where sickness levels were high at the time group interviews were being conducted. This meant that either participants were unable to attend due to personal sickness, or were unable to be released from clinical duties. As the groups were conducted within the clinical environment, this was unavoidable. Site B was undergoing major structural changes within the provision of maternity care. This may have accounted for the low response

rate. The head of midwifery at Site D was very supportive of the study, giving midwives allocated time to attend the group. This may reflect the high response rate. Groups were homogenous in terms of gender (all midwives were female), age and academic qualifications. Group demographics are given in table 5c below. All midwives in all four groups had a diverse range of clinical experiences. However, only one pre-registration[12] midwife was included in the group interviews. This may be considered one limitation in the study.

Table 5c: Group demographics

Site	Age category	Pre-reg or post-reg midwifery training	Number of years as a practising midwife / Grade	Areas worked (see key below)
Site A (CLU Higher rate of normal birth)	26-35 (n=2) 36-45 (n=1) 46-55 (n=2)	Post-reg (n=5)	4-26 years Grade F (n=3) Grade G (n=1) 1 not stated	1 (n=5) 2 (n=5) 3 (n=3) 4 (n=5) 5 (n=1) 6 (n=0)
Site B CLU lower rate of normal birth)	36-45 (n=2) 46-55 (n=2) Over 55 (n=1)	Post reg (n=5)	16-29 years Grade F (n=0) Grade G (n=5)	1 (n=3) 2 (n=4) 3 (n=1) 4 (n=1)
Site C (MLU higher rate of transfer)	26-35 (n=1) 36-45 (n=4) 46-55 (n=4)	Pre reg (n=1) Post reg (n=9)	3-29 years Grade E (n=1) Grade F (n=3) Grade G (n=5)	1 (n=4) 2 (n=8) 3 (n=7) 4 (n=5) 5 (n=9) 6 (n=1)
Site D (MLU lower rate of transfer)	36-45 (n=2) 46-55 (n=1)	Post reg (n=3)	18-20 years Grades not stated	1 (n=3) 2 (n=3) 3 (n=3) 4 (n=2) 5 (n=3)

Key to areas worked:
1. consultant unit (delivery suite)
2. community
3. Antenatal / postnatal ward
4. consultant antenatal clinic
5. midwifery led unit
6. birthing centre
7. other

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[12] Pre-registration or direct entry midwives have undergone a period of training to become registered midwives. Post registration midwives' are registered nurses who have undertaken a period of midwifery training, and are therefore both registered nurses and registered midwives.

Group interviews lasted between 30 minutes to 75 minutes. As the groups consisted of midwives known to one another, it was impossible to control pre-existing power relationships. However, the moderator tried to involve all participants in the discussion. Inevitably, some participants dominated the discussion at times.

Group interviews were tape recorded and transcribed verbatim. This process is generally recommended in the literature (Sim 1998). Although three of the tape recordings were externally transcribed, they were thoroughly re-checked by the researcher for level of accuracy. Field notes were used along side the transcripts during this process. No identifiable characteristics were used when transcribing the data. Once transcribed, interview tapes were stored in a locked filing cabinet. No one other than the research team had access to the tapes or transcripts.

5.9 Phase 2: Individual Interview method: Recruitment process

Ethics approval was sought from the local ethical committee for the second phase of the project. Approval was sought from the R&D department, and head of midwifery in each participating site. Permission was obtained from 3 sites. The fourth site was therefore excluded from this phase of the study. Participants from the original group interviews were contacted via letter and sent an information pack inviting them to take part in a follow up interview. This took place between 21-27 months following the original group interviews [13] Three responses were received.

It is acknowledged that including participants who had already been involved in the prior group interviews may have influenced the data, as participants had prior knowledge of the phenomenon to be explored. However, due to financial limitations and restrictions of time, it was considered that this method of selection was most appropriate.

Conducting the Interviews

Wood (1991) argues that only one initial question should be asked in a phenomenological interview to allow for participants spontaneous accounts of the phenomena to be uncovered and explored. This allows data to be gathered without

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[13] The time between original group interviews and individual interviews was influenced by a break in the research due to the researcher taking maternity leave.

further guidance or prompting from the researcher. Despite this, it may be argued that all interviews require structure in order to facilitate discussion appropriate to the research question (Britten 1997; DiCicco-Bloom 2006).

Interviews were conducted between January and February 2007. Interviews were initiated using the following open ended question; *'Tell me about your experiences of working with a midwife whom you regard an expert in intrapartum care'*, and a series of prompts (based on the findings of the systematic review and group interviews) were noted to initiate discussion around aspects of the phenomenon if required (see appendix 3, pg 154).

Participants were contacted via telephone by the researcher to arrange the date, time and location of the interview. The environment in which the interview is undertaken may be argued to significantly influence the relationship between participant and researcher, and thus the quality of the data obtained (Elwood & Martin 2000).

Morton-Williams (1985) alludes to power relationships within different environments and recommends researchers consider these issues when conducting interviews and interprets the data. Thus the skill of the researcher is pivotal to the success of the interview. The researcher must consider issues of power and relationships between researcher and participant, and work to facilitate a secure environment founded on trust and mutual respect (Taylor 2005). Interviews were therefore conducted at a time and location specified by the participant to facilitate maximum participation. One interview was conducted in the participants' working environment, two were conducted in the participants' homes.

Thoughts about the interview questions and responses were documented in the field notes, and also in a reflective diary. Field notes were documented immediately following each interview and not taken during the interview process. This process allows researchers to lay open their presuppositions, and is suggested as an integral part of the interpretive process, supporting the credibility and trustworthiness of the research findings (Lowes & Prowse 2001).

5.10 Summary

This chapter has addressed the issues surrounding the two methods used for data collection, and how they fit within the underpinning methodology. Group interviews allowed for the phenomenon to be examined in a group context, whilst the follow up individual interviews allowed a more in-depth rich description of expertise. Both methods appear congruent with the underpinning philosophy and theory.

The following chapter will outline the analytical process undertaken through the research study.

6.0 Analysis

6.1 Introduction

The aim of this chapter is to discuss the analytical process undertaken during the empirical phase of the research. This chapter will address the analytical process of the group interview and individual interview data.

The chapter will present an overview of qualitative analysis and analysis of phenomenological data. The analytical process undertaken for both stages 1 and 2 of the study will be explored. Finally, attention will be paid to aspects of rigor, credibility and trustworthiness.

6.2 An overview of qualitative analysis

The aim of qualitative research is to '*explore underlying social processes and values in their particular social context, to lay open the individuals experiences and inferred meanings*' (Froggatt 2001, p433). The main feature of qualitative data is its richness providing '*"thick descriptions" that are vivid, nested in a real context, and have a ring of truth that has a strong impact on the reader*' (Miles & Huberman 1994, p9). In order to generate knowledge from the research findings, the researcher must engage in the process of data analysis (Thorne 2000), transforming the raw data, to allow the reader to understand the social context of the phenomenon under scrutiny (Basit 2003). Qualitative data analysis may be described as the interaction between the researchers and the data (Strauss & Corbin 1988), being a dynamic, intuitive and creative process (Basit 2003). The process of analysis itself is not conducted at the end of the project, but as an ongoing process throughout the research process (Basit 2003).

Morse (1994) argues that although various methods of qualitative data analysis are proposed, they all involve a process of comprehending the phenomenon under study; synthesis of the phenomenon, recognizing links and relationships, theorizing about these relationships, and finally putting this new knowledge into context.

6.3 Analysis of phenomenological data

The theoretical lens from which the researcher approaches the phenomenon, the data collection method adopted, and any presuppositions the researcher brings to the research, are all processes that influence the data (Thorne 2000). There appear to be a wide range of analytical strategies suited to phenomenological research. Navigating through this terrain of complex information may prove to be a difficult task, especially for the novice researcher. Due to limitations of space, it would be impossible to discuss the alternative approaches to phenomenological analysis in detail. Instead, the chapter will focus on the analytical strategies suited to hermeneutic or interpretive phenomenological methods.

Rapport (2005) suggests that in an interpretive-phenomenological or hermeneutic research study, data analysis allows the researcher to *'objectify and interpret accounts in order to understand more clearly the world of the research participant. Interpretation depends heavily on the use of personal historical background, concentrating on one's own response to the language used by the participant, which carries along with it history and tradition'* (p134). In interpretive-phenomenological or hermeneutic research, it may be argued that the researcher is an active participant in the analytical process, with the researcher's personal experiences, values and beliefs enriching the interpretation of the data (Walters 1995; Draucker 1999).

The methods proposed by Diekelmann and colleagues (1989), and Van Manen (1990) appear to fit within the methodological and theoretical framework of this study.
Both methods involve a merging of the participant data and the research team's understanding of the phenomena being studied. The analytical process allows for individual meanings to be explored, giving descriptions or accounts of the phenomena in the participants' own words (Rapport 2005).

6.4 Analytic process undertaken during the research study

The specific analytical approach used for both group interviews and individual interviews was an adaptation of the methods stated by Van Manen (1990) and Diekelmann et al (1989). An example of the process of the analysis is given in the appendix 4 (p155), and is outlined below:

1. Interview transcripts read and re-read to obtain an overall understanding.

2. Codes and possible themes identified within the transcripts.

3. Identify patterns that link the themes.

4. Comparing and contrasting transcripts to identify shared practices, common meanings, and similarities between codes and themes

5. Return a summary of the analysis to the participants to verify findings

6. Final interpretation reviewed by the research team.

Although Thackeray and Neiger (2004) suggest that group interview data may be analysed using phenomenological, grounded theory, content analysis or narrative analysis methods, they suggest that the group analysis approach does not fit within the pure phenomenological framework. However, the process appears to fit within hermeneutic analysis (Van Manen 1990).

The only difference in approach to analysis of group interview and individual interview data was the attention paid to group dynamics. Carey & Smith (1994) argue that the main aim of analysis is the ability to identify areas of agreement and controversy, and to understand how perspectives arise and are modified in a group environment. However, Turner (1991) contends that complete agreement may be exaggerated by the 'group polarization effect'. This occurs when a viewpoint is shared by most of the group. In addition, conformity and compliance may be a problem, with participants apparently agreeing with one particular opinion, despite holding different beliefs, or saying what they think the researcher wants to hear (Maguire, 1998). Kidd & Parshall (2000) suggest the researcher should devise flexible analytical approaches to be able to identify any influences on group or individual participants, to ensure that apparent agreement did not result from coercion, conformity or compliance. In order to address these issues, although group interaction was not the main focus of analysis, attention was paid to specific instances where areas of debate or agreement were evident in the transcripts. This process will be explored in the following section.

6.4 The analytical process

6.4a Stage 1. Group interview method

Transcripts were read several times. Statements or words that appeared to be significant were highlighted and their context explored to capture the whole meaning. Statements were then brought together to form themes. Quotes that represented the essence of these themes were brought together and analysed further, again to capture the full meaning. This process was repeated for all four group interview transcripts.

Following the initial reading of the group interview transcripts, and the preliminary identification of emerging themes, the researcher met with two other members of the research team (SD& KT) who had also undertaken this process. This allowed an in-depth discussion of common codes, and also identified areas that required further investigation. The analytical process was highly iterative and reflexive. At each stage, researchers met to discuss emerging themes in more detail. This allowed for the researcher's 'decision trail' to be followed, and also for themes to be developed and refined (Rapport 2005).

Once codes had been identified in each group interview, themes across the interviews were compared for similarities and differences. Further exploration allowed for overarching concepts or themes to be identified, which described the essence of the phenomenon under study. Although an examination of group dynamics was not the main focus of the analysis, it was possible to identify common ideologies within the groups and across the groups. Through verbal communication and debate, there were many instances where the strength of agreement (or disagreement) was evident as represented by the following two quotes;

Mw1 'And you've got that monitor as well, you've got a monitor there, you've got a partogram haven't you with...'
Mw2 'yeah but you've got to have [that] *in* [a] *hospital setting haven't you, you know* [you're] *dictated to*
Mw3 'But you've got a partogram at home...You have a partogram at home (yeah).
Mw2 'But the monitoring you don't...'
Mw3 'I know but [you] *don't have to plug it in...But you don't have to, ...the policy is that we have this admission trace, (yeah) but then you can chuck your monitor in the back room and manage everybody normally'.*
Mw2 'Yeah but only for, only for 2 hours and then you've got to put them back on it again [the shift leaders say] *what's you're monitoring like? I've not had her on a*

monitor. Why've you not had her on a monitor? Well!' (GI CLU A)

"get her ARM'd we need to get her delivered because after 3 o'clock there's only 3 midwives' on" and she said "no, she's in normal labour, she'll be delivered way before then, I'm not doing it". (Nice one). And, you know, but it's wonderful that (good on them) (yeah it is, pressure), (pressure as well) ...who feels strong to do that, than perhaps somebody who was, more junior might not of had the confidence to do that (indeed), it would have been an unnecessary intervention perhaps tipping the woman over the edge with pains. (yeah)" (GI CLU B)

The first quote highlights debate amongst participants surrounding the routine use of fetal monitoring in low risk labour. Through this debate, it was possible to identify and explore conflicting ideologies of intrapartum care and intrapartum expertise

The second quote demonstrates how other participants in the group (as represented by the text in brackets) agree with the main participant. Time and staffing pressures were commonly identified as a reason for unnecessary intervention in childbirth. The main theme represented by the quote is the courage that is required to challenge senior colleagues. The ability to recognise individual perceptions of expertise and how these perceptions may be influenced in a group context appears to be a main strength of the method.

The process of writing was an iterative process, continuing until the researcher (and research team) felt the relationships between themes had been captured as accurately as possible. Prior to the final write up of findings, a summary outlining the main concepts and themes was sent to the participants for 'member checking', to determine the plausibility of the main findings (Higginbottom 1998). This process may be suggested inappropriate to phenomenological research as the researcher's understanding is regarded a valid interpretation of the data (Webb & Kevern 2001; Holloway 2005). However, within hermeneutic research, confirming or constructing meaning with the participants is considered an essential process during the analytical process, as it is their meanings that are being described. Therefore, member checking is suggested as an integral process of hermeneutic or phenomenological analysis (Diekelmann et al 1989; Draucker 1999).

6.4b Analytic process: Stage 2: The individual interview method

Transcripts were tape recorded and transcribed by the lead researcher. Field notes were used alongside the transcription process. Again, the process of analysis was highly iterative. The analytical process undertaken for individual interviews was structured on the process described above. However, only two members of the research team (LS & SD) were involved in this stage of the research.

6.5 Issues of transferability, credibility and trustworthiness

Koch and Harrington (1998) argue qualitative research is often criticised for lacking "scientific" rigour, with the most commonly reported criticism of qualitative research being that it *'is anecdotal, impressionistic and strongly subject to researcher bias* (p884). The terms "reliability" and "validity" and "bias" are often used to describe rigour in qualitative research (Koch & Harrington 1998). However, these terms may be more suited to quantitative research, and it may be argued that they are inappropriate or problematic in qualitative research due to the subjective nature of qualitative inquiry. This is of particular significance to phenomenological research, where the individual presuppositions and beliefs of the researcher are a vital part of the research process (Koch & Harrington 1998).

Priest (2002) suggests that in order to demonstrate rigour in qualitative research, is essential to determine whether the study is believable, accurate, right and whether the data are useful beyond those participating in it. Lane and colleagues (2001) suggest the concept of rigour, can be considered on a number of levels; including *'embracing its philosophical underpinnings, the participation of the researcher in the data production and manner in which the credibility and authenticity of the researcher may be validated' (p53).*

The following terms; transferability, credibility and trustworthiness will be used to capture the essence of rigour in qualitative research. Credibility refers to whether the data accurately describes the phenomenon under study (Holloway (2005). Trustworthiness relates to the credibility of findings, and suggests an element of trust between the readers of the research and those who have conducted it (Holloway

2005). Transferability refers to applicability of the research findings to other clinical contexts.

The main strength of the qualitative interview method is that it allows for rich and in-depth information about the experiences of individuals to be uncovered and explored about a particular phenomenon (DiCicco-Bloom & Crabtree 2006). The ability of participants to either validate or refute information given by others is considered a strength of the group interview method (Kitzinger 1994; Robinson 1999). Thus, group interviews are suggested to have 'high face validity' (Nyamathi 1990). However the group-interview method may raise some issues with regards to generalisability of findings as group interview data are '*firmly contextualised within a specific social situation....*' (Sim 1998). Thus, what a person says in one particular group situation is subjective, and may not reflect what they would say in other social situations (Sim 1998). Different results may be obtained if different groups were used. Guba & Lincoln (1994) argue that the goal of qualitative research is not to provide statistical generalisability, but to allow the findings to be transferred to other social settings. Some authors have described this phenomenon as theoretical generalisation (Sim 1998). '*Here the data gained from a particular study provide theoretical insights which possess a sufficient degree of generality or universality to allow their projection to other contexts or situations which are comparable to that of the original study*' (Sim 1998, p350).

Within phenomenological or hermeneutic research, it is expected that no two researchers would find exactly the same themes, as personal beliefs, experiences and prejudices would influence the process of data collection and analysis (Webb & Kevern 2001). Thus, researchers are active participants in the phenomenological or hermeneutic research process (Crotty 1998). With regards to credibility in phenomenological or hermeneutic research, findings are regarded as plausible or credible if the researcher has communicated a systematic and thorough approach to analysis (Webb & Kevern 2001). This can be achieved through the researcher maintaining an audit trail or reflexive journal throughout the research process (Koch 1996; Froggart 2001; Rapport 2005). Froggart (2001) suggests the reflective journal allows for analytical decisions to be made explicit, charting the development of

thoughts and ideas, providing evidence of why particular decisions were made. These reflective thoughts are presented and explored in the following chapter.

6.6 Summary

This chapter has explored the concepts of qualitative and phenomenological analysis, and outlined the analytic process undertaken during this study. The analytic process allowed for shared and individual meanings about the phenomenon to be captured and explored, paying particular attention to the effect that the group context and culture had on individual meanings and perceptions. The chapter has focussed on how the process of analysis is influenced by the underlying methodology and theory, and highlighted ways in which aspects of transferability, credibility, and trustworthiness have been addressed.

Issues surrounding reflexivity and how personal experiences, prejudices, and prior beliefs may have influenced the data will be presented in the following chapter.

7.0 Reflexivity

7.1 Introduction

It is the responsibility of the researcher to present a credible piece of research demonstrating transferability and trustworthiness (Holloway 2005). Failure to do so would be unethical. This can be achieved through the justification of the use of research questions, epistemological and theoretical perspective, and methods of data collection and analysis. Attention must also be paid to the role of the researcher in the research, and how this may have affected the credibility of the evidence (Avis 2005). This can be achieved through the process of reflexivity, presenting a transparent account of the research process (Avis 2005).

The aim of this chapter is to give a brief introduction to the concept of reflexivity, and to give a reflexive account of how I as a researcher may have influenced the outcomes of the research. The chapter will be divided into two distinct sections, the first paying attention to the concept of reflexivity in general. The second part will be divided into three sub-sections with aspects of reflexivity being addressed through (i) my role as a researcher; (ii) the data collection stage; and (iii) the data analysis stage. Each subsection will present an overview of important concepts, with reference being made to extracts from my own personal reflexive journal maintained through the research process. Issues arising from this personal account will then be subject to further exploration and debate, and grounded in the context of current research literature.

7.2 The nature of reflexivity

Reflexivity may be argued to be an important concept in qualitative research in its ability to add credibility to the research findings (Hand 2003). Although controversy surrounds the definition of reflexivity, Dowling (2006) argues it is often narrowly viewed as 'the analytic attention to the researchers' role in qualitative research' (p8). Finlay (2002a) suggests that reflexivity has the potential to 'examine the impact of the position, perspective and presence of the researcher; promote rich insight through examining personal responses and interpersonal dynamics; open up unconscious motivations and implicit biases in the research approach; evaluate the research process, method and outcomes; and enable public scrutiny of the integrity of the

research through offering a methodological log of research decisions' (p532). To summarise, reflexivity is suggested to maintain quality and rigor within qualitative research; acknowledge the researchers role in the research process; and to justify decisions made through the process of data collection, and analysis (Denzin & Lincoln 1994).

However, achieving reflexivity may be argued to be a complex task, with little research evidence offered to support the practicalities and processes involved (Finlay 2002a; Atkinson & Coffey 2002; Mauthner & Doucet 2003; Carolan 2003; Dowling 2006). As previously alluded to, the definition of reflexivity remains ambiguous. In addition, the terms reflexivity and reflection are often used interchangeably in the literature (Lamb & Huttlinger 1989; Finlay 2002a). Finlay (2002a) suggests that the terms reflection and reflexivity be regarded as two opposites on a continuum, with reflection being characterized by the ability to contemplate a situation, usually after the event. In contrast, reflexivity *'taps into a more immediate, continuing dynamic and subjective self-awareness'* (Finlay 2002a p532). Thus, reflexivity requires the researcher 'being aware in the moment' of the possible factors influencing the research (Dowling 2006).

However, Doucet and Mauthner (2003) contend there is a limit to our ability to be reflexive; *'how far can we know and understand what shapes our research at the time of conducting it, given that these influences may only become apparent once we have left the research behind and moved on in our personal and academic lives' (p415)*. In addition, Finlay (2002a) proposed that the level of self-critique that is required during the reflexive process may prove a difficult process, especially if the researcher has to lay open to the public errors in method or judgement. Despite the difficulties suggested in the approach, an attempt will now be made to outline the research process and how I as a researcher have addressed issues of reflexivity through the process of the research.

7.3 The impact / role of the researcher

Finlay (2002a) argues that the researcher is a central figure in the research process influencing, if not actively constructing, the selection, collection and interpretation of the data. In order to enhance the credibility and trustworthiness of their research,

most qualitative researchers will clarify their role and try to make explicit how individual factors such as their own personal assumptions and background, and their own biographies, experiences and history may have affected the research process and consequently their research findings (Finlay 2002b; Carolan 2003; Holloway 2005).

It may be argued that reflexivity *'is a concept that is deeply embedded in both our perceptions of self and our perspectives of the world, which ultimately is connected to our personal stance'* (Salvin-Baden 2004, p366). According to the Oxford online dictionary, a stance is an attitude or standpoint. Thus, personal stance refers to the 'position' each of us takes in life (Salmon 1999). The following paragraph is taken from my research diary and represents my thinking as the researcher process commenced;

"As a midwife, a researcher and a mother myself, I am concerned about how these three roles may impact on the research process. Firstly as a midwife, my midwifery philosophy is that of promoting normal birth. I hold a strong trust and belief in the normal processes of labour, and feel that this is an important aspect of midwifery practice. In addition, although I feel that midwives are autonomous practitioners within this area, I believe that many midwives have lost faith and trust in their own ability and are losing the required skills for keeping birth 'normal'......On reflection, I suppose I have come into this research with my own prejudgements about what I consider important aspects of midwifery expertise. I can immediately think of a midwife who I would regard an expert. I can therefore think of the skills and attitudes that I think make her an expert...."

It would be impossible to present all my thoughts and intuiting about the research process. However, this extract suggests that I was aware that my experiences as a mother of two children (the second being born during the process of this research), as a midwife and as a researcher, may have played a significant part in the development of the research topic and research question, and thus influenced the outcomes of the research. It may be argued that the fact that I was a midwife myself was one of the main factors that may have influenced my research. The following quote represents my thoughts on the rationale for undertaking the research;

".... I think midwifery has changed so much in the last 9 years that I have experienced it. I think that many midwives are losing the value of the 'with woman' approach and tend to be orientated towards 'with machine'. I think many midwives, even myself at times, fear normality.... I think we need to regain that

trust in normality, and shout out loud how we can achieve that as midwives.... I'm scared about what the future of midwifery will be if students don't experience normality. If all they see is intervention, then how can we as a profession of midwives' retain our claim that we are experts in the normal?"

On reflection, I feel that it was the dramatic changes in the practice of midwifery, low morale and high work-load that was the primary reason for doing this research. As a midwife myself I felt frustrated with current practice, and I wanted to be able to challenge this practice, and to promote optimal birth outcomes and women centred care.

It is acknowledged that personal stance may change or be influenced by the research process. This was evident in the current study. I started the research with the fundamental belief in normal birth. However, my trust in the process has become strengthened during the research process;

"...when I look back at how I used to practise as a newly qualified midwife I cringe. I suppose it was probably the way I was 'conditioned' during my training... my mentor always defined full dilatation as soon as a woman had the first urge to push.... So I did the same. I look back now and think that probably accounted for why I had a long period of instrumental deliveries, fetal distress etc... I didn't give women time; I didn't have the confidence or trust in my own ability as a midwife.... It really makes me sad when I look back. At the time I probably didn't realise, but all that reading about expert practice, and confidence and competence made me think about and challenge what I was doing. It didn't happen over night, but I think this research has made me stronger as a person and a better midwife..."

I have already explored the effect the researcher may have on the research process. But this extract leads me to question and acknowledge the effect of the research on the researcher. However, there is little evidence to support the nature of the effect (Hand 2003; Allen 2004). This is likely to be due to the fact that this is individual, being dependent upon the nature of the research and the personal stance of the researcher.

If I reflect upon the research process, I think that this research has influenced my practice and me as an individual in a number of ways. As presented in the short extract, the research made me look at and question my own practice. I suppose I undertook a process of self-critique. However, I don't think that I was aware of this

process until later in the study. From reading research literature and from talking about midwifery practice, I began to build my own confidence and trust. When I reflect back, changes were subtle. I started to challenge the need to define full dilatation, and began to trust women's ability to 'know'. I encouraged mobilisation and practised subtle midwifery interventions, and valued the art of midwifery practise. I have become a stronger, more competent practitioner.

As a person, I have also become stronger. Through the research process, I have gained the confidence to challenge routine practices that undermine women and undermine normal birth. Speaking at conferences and local study days has allowed me to cascade this information, and hopefully in time, this will have an effect on individual midwives' practices.

7.4 Data collection

The data collection stage begins with the nature of the research topic itself, and the epistemological position of the researcher. Mauthner & Doucet (2003) propose *'the "choices" we make in our research with regard to ontological and epistemological positioning, methodological and theoretical perspective, and the adoption of particular research methods are bound up not only with our personal or academic biographies, nor are they motivated exclusively by intellectual concerns' (p421).*

Thus, in order to be reflexive during the research process, the researcher is required to question themself about how the research question may have been addressed differently, and how the research question itself may have limited or influenced the findings of the research (Dowling 2006). As discussed in the previous section, researchers must pay attention to personal assumptions, motivations and interest in the research and how these may have influenced the outcomes of the research. Finlay (2002a) proposes that researchers should reflect on the research topic and their relationship with that specific topic, with the process of reflexivity being continued throughout the process of the research (Finlay 2002a). This can be achieved through maintaining a research diary or audit trail of the research processes and decisions. Maintaining an audit trail or reflexive journal is regarded an essential process in qualitative research to facilitate the credibility of such research (Koch & Harrington 1998).

Data collection process

In the selection and analysis of research papers during the initial review, three members of the research team presented their views and interpretations on the selected papers. This process was highly iterative in order to identify any disconfirming data, and to ensure that personal values and beliefs had not influenced the selection of papers, nor any conclusions made. In the subsequent research study, the aim was to gain multiple perspectives and a range of midwives' views on the phenomenon 'midwifery expertise'.

I think at an early point in the research process, I was aware of the need to be reflexive. My prior assumptions of the philosophies, beliefs and practices of midwives working in different environments resulted in selecting participants practising in consultant led units and midwifery led units. One consultant led unit had a high rate of normal birth, the other a lower rate of normal birth (as defined by Birth Choice UK). In the initial research proposal the sample selection was justified by stating *'The rationale for the nature of sites which we have specified is that they can be expected to cover a range of philosophical approaches to childbirth'*. However, given further reflection on this concept, I feel that it was our own pre-judgement or preconceived ideas about what differences we anticipated in the philosophy and practice of such midwives. The following extract was taken from my diary following a group interview;

'I can't help feeling surprised, shocked after this group interview... I really thought that midwives working in a unit with such a high rate of normal birth would be so pro-normal....I can't believe some of them considered epidurals to be normal'

My own prior beliefs therefore influenced the selection of participants. I assumed that midwives working in midwifery led units would generally hold a strong belief and confidence in normal birth, midwives working in a consultant led unit with a low rate of normal birth would predominantly value and use interventions, and those working in units with a high rate of normal birth would be predominantly 'pro normal'. These presuppositions were unfounded. In order to prevent these pre-suppositions influencing the data collection, each of the group interviews were conducted using the

same research schedule, tape recorded and transcribed verbatim, with field notes being recorded in the research diary.

The methods used to collect data were also influenced by personal experiences, pre-suppositions, values and beliefs. An orientation towards phenomenological research, placing value on individual meaning and perspectives, inevitably led to the research team using interviews (individual and group) as the primary method of data collection. However, my orientation towards the value of the methods chosen changed during the process of the research;

'I'm not quite sure if I would choose group interviews as the primary method of data collection if I were to do this study again. I think that the group interviews were valuable in their ability to give a range of views, and a lot of themes emerged from the data...but the data from the individual interviews had so much more depth. I don't think that the data from the group interviews was superficial, It's just the individual interviews had so much more.... I wish that I had done more of them....'

Thus, reflexivity allowed me to consider and reflect on the strengths and weaknesses of the methods employed, allowing me to identify any limitations and ways in which the research process could be improved.

Another aspect to take into consideration when reflexively analysing data collection methods is the relationship between the researcher and research participant. Holloway (2005) proposes *'reflexivity involves not only reporting on or describing the reality of the participants but also shows how the research story came about, how it was constructed and how the researchers voice complements that of the participants and sometimes even shapes it' (p279-280).* Finlay (2002b) suggests that the power imbalance between researcher and participant may be a concern for researchers.

When reflecting on the research process, I feel that there was only one instance where I felt power relationships were evident. The following extract from my research diary represents this issue;

'I felt uncomfortable with her from the start..... She had already made it clear that she was busy before I started the interview. I felt rushed and pressured. I didn't

think that she really wanted to be there. To be honest, I'm not sure that she really understood why she was there. The interview was awkward and almost like 'pulling teeth"

When reflecting on this interview, I am unsure whether it was the power dynamics, the inexperience I had at conducting interviews, the fact that the participant didn't really understand what was required from the interview, her apparent nervousness, the location of the interview, or a combination of all the above which led to this interview being 'difficult'. As I only conducted three individual interviews, it is difficult to make direct comparisons. The only difference between the three interviews was that this one was conducted within the midwifes' working environment, she was on duty, and had time and pressure constraints. The other two were conducted in the midwives' own home, they were off duty, and had the time to participate;

'I felt nervous at first as it was my first interview. I was alone, and I would be transcribing this interview, and everyone would be able to see how good (or bad) I was at interviewing.....However the atmosphere was so relaxed.... We just chatted... it didn't feel like an interview. Interruptions from the dogs as they clambered over me during the interview didn't feel like an interruption....I was at ease, she was at ease....'

It may be that a different environment, one in which both the researcher and participant felt comfortable may have facilitated a more relaxed interview. However, despite the difficulties in this interview, valuable data were obtained. On reflection I feel that any difficulties with power dynamics, was evident only in the conduct of the interview, and not the analysis or interpretation of findings.

7.5 Analysis of Interview data

'The shift between analysis and interpretation is a complex one that is often overlooked, yet there is something of a personal epiphany for many of us about the transition made from analysing data to interpreting them' (Salvin-Baden 2004, p368). Mauthner & Doucet (2003) contend that reflexivity at the data analysis stage also involves the researcher examining the ontological and epistemological assumptions built into particular methods of data analysis.

In the current research project, all three members of the research team were involved in the analysis of group interview data (LS, SD,and KT). Again, this process was highly iterative in order to identify any disconfirming data, and to ensure that personal values and beliefs had not influenced the emerging themes, nor any conclusions made. I, as the lead researcher, took the lead in the analysis of group interview, and individual interview data. A second member of the research team (SD) independently reviewed the transcripts of the individual interviews.

The analytical process itself involved a period of reflection and intuiting, through reading and re-reading the transcripts. This process enabled me to challenge or take into account personal beliefs, knowledge and experiences, and to consider the available literature on the phenomenon under study.

'I am all too aware that when reading the transcripts I am looking for the themes that are already running through my head.... Maybe I unconsciously do this when reading the transcript for the first time..... But the more I read it, the more I feel that I become open to new arising themes...... I'm glad that we meet as a research team to discuss our interpretations... In a way it makes me feel that I'm analysing it correctly.'

On reflection, I appeared to analyse the data from different perspectives. I tried to situate myself as a midwife, then as a researcher, and then as a participant;

'I've tried to analyse the transcripts with different hats on. I've looked at them through my own eyes (as a midwife, a mother and all that baggage that I bring), as a researcher, and from the perspective of the participant... it's been a lengthy process, but one that will be fruitful in its rewards'

Salvin-Baden (2004) argues that the ability to situate oneself in the research is a complex task, as perspectives change as we undertake the research. The process requires the researcher to understand people's experiences of the phenomenon under study, and also how these experiences are influenced (or not influenced) by the past, present, and the future. Salvin-Baden (2004) also contends that the participant's perspectives must remain at the centre of data interpretation. Returning transcripts or data to participants for validation is one recommended way of facilitating the credibility of qualitative research.

In the current study it was felt that returning a large volume of group interview transcripts would have been inappropriate, and therefore a decision was made to return a summary of the interpretation arising from group interview data to participants. The summary presented a list of key emerging themes supported by quotes that represented the concept. I wanted to find out whether I was representing their ideas and their 'real world' interpretation of midwifery expertise. Participants were given the opportunity to reflect and comment on the main findings. One participant commented *'participating in the group focussed my thoughts on what I really do and tried to define expertise. Also sparked debate after the session'*. There were no negative responses from participants.

The final aspect of data analysis is in the interpretation and presentation of the findings. Quotes or excerpts from the transcripts can be used to support the main themes, but Holloway (2005) contends that these are not raw data. *'The data have already been transformed in the process by the researcher. Even the choice of quotes, quotations and field notes plays a part in the transformation of data in the research story'* (p281). Thus, qualitative research requires a degree of honesty from the researcher (Fontana 2004).

7.6 Summary

In order to give credibility to qualitative research, attention must be paid to the researchers' role, their prior beliefs and experiences, acknowledging the effect of both the researcher on the research, and the research on the researcher. Dowling (2006) argues *'reflexivity encourages the researcher to reflect upon their assumptions..., that are made in the course of the research, and helps the researcher think about the implications of such assumptions for the research and its findings'* (p11).

This chapter has addressed the role of the researcher in the research process, given a reflexive account of data collection and analytical methods employed in this research, and addressed ways in which rigour or credibility has been maintained through the research process. When reflecting on the research process using my reflexive diary as an audit tool, I feel that I am able to demonstrate the credibility of my research. Although I had my own personal beliefs and values about the necessary skills and characteristics that made a 'good midwife', or 'expert midwife', I tried not to let these

assumptions guide or influence the initial review of the literature, or nature of the research.

I was aware that it was both an advantage and disadvantage that I was a midwife myself. I acknowledged that participants and I would share values and belief, and that there would be instances where our beliefs differed. I had to guard against making the assumption that specific language used represented the same phenomenon, or put simply, that we saw the job or nature of midwifery, and midwifery expertise the same way. If I were to be oblivious to these differences, then I would have missed a vital aspect of this research.

The process of reflection and reflexivity has proved beneficial to me as a midwife and as a researcher. It has allowed me to justify decisions made, confirming the credibility of the research process.

The following chapters will present the findings of the empirical phase of the research study.

Introduction to the findings chapters

Siddiqui (1994) argues *"there is a plethora of unexplored knowledge which is midwifery; this knowledge will not be recognised and compensated unless midwives can describe how expert midwifery practice is acquired"* (p420).

The findings of this study will be presented in five chapters. The first chapter titled 'Today I'm a labour ward midwife, tomorrow I'm a community midwife' explores the cultural context of midwifery practice, identifying how both the culture and context of midwifery affects expert intrapartum care.

The subsequent four chapters will address the perceptions and individual meanings midwives placed on the phenomenon 'midwifery expertise' during the data collection from the current study. The findings will be explored using four themes arising from the data collection and analysis. Three of these are similar to, and deepen the synthesis of the review. The fourth theme (connected companionship) is new and only arose in these data.

1. 'Today I'm a labour ward midwife, tomorrow I'm a community midwife'
2. Wisdom
3. Skilled practice
4. Enacted vocation
5. Connected companionship

Comparisons and links will be drawn to the findings of the prior literature review, and current research evidence.

8.0 Findings chapter 1. 'Today I'm a labour ward midwife, tomorrow I'm a community midwife'

Introduction

The aim of this chapter is to give a situated account of the current culture of midwifery practice, and how both the culture and context of midwifery affects expert midwifery and midwifery practice in general. This chapter will be divided into the following two sections: 'The cultural context of midwifery practice', and 'reaction to the context of childbirth'. Within each section, a brief review of the current literature will be presented, followed by empirical data from the current study[14]. Due to the nature of phenomenological research, many of these quotes may be presented in long text to situate participant's quotes in context, and to allow participants meanings to be revealed.

8.1 The cultural context of midwifery practice

Within this section there appear to be three key themes relevant in the findings:

1. Integrating the differing ideologies of midwifery practice
2. The concept of time in midwifery
3. Influences of prior experiences on midwives' values and beliefs

8.2 Integrating ideologies of midwifery practice

Hunter (2004) suggests that attempts by midwives to work across opposing ideologies of midwifery caused emotional conflict for midwives. In her study, hospital and community environments *'presented fundamentally different work settings with diverse values and perspectives'* (p266). Hospital based midwifery appeared to be driven by the needs of the institution. Care was standardised, and attention was paid to risk reduction, efficiency and cost effectiveness. Community based midwifery appeared to be fundamentally based on a 'with woman' approach. Care was

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[14] Quotes from the data will be referenced using the following coding technique: GI (Group interview), II (Individual interview), CLU A (Consultant unity with higher than UK national rate of normal birth), CLU B (Consultant unit with lower than average UK rate of normal birth), MLU C (Free standing MLU- higher rate of transfer), MLU D (Freestanding MLU- lower rate of transfer). Quotes from group interview data will use brackets to identify other members in the group who interrupt discussion.

'characterised by an individualised, woman centred model of care, informed by a belief in the normal physiology of birth' (P266).

Similar findings were evident in an earlier study conducted by McFarlane & Downe (1999). In this paper, the authors identified the implications of integrating the hospital and community midwives in order to provide a continuity of carer scheme. Participants identified the difficulties in balancing home and work life, and identified the implications of different philosophies on their practice. The main problems reported was the feeling of 'not belonging' to either hospital or community ways of working, and a feeling of dissatisfaction with the care that they were giving.

Data from the current study revealed similar findings. Participants highlighted the difficulties they as midwives experienced working in fundamentally different working environments (free-standing units, community and hospital). This is reflected in the following two quotes;

'It was VERY strange to begin with, coming from a consultant unit, where everything, all the decisions were made for you. I remember when I first came down we still had consultant input, but we had lots of GP input as-well. So there was an awful lot more of teamwork. You were encouraged to voice your opinion. And then I'm thinking, Oh I've got to have an opinion now! You know what I mean, It was really odd..... And certainly working in that environment, since we've been midwife led, that has been magnified again, and again, and it's a challenge, and I know that some of my colleagues don't feel comfortable with that' (II MLU C)

"I mean I used to be like shift leader on delivery suite, but now that I'm on the team, when I went back in once one of the shift leaders said "oh you're just like a community midwife now" I said "well I am a community midwife" I said "what do you mean?" and they just said "oh, you've slowed down so much" (laughter). (Slowed down). (GI CLU B)

In the first quote, reference is made to the differences in the role and responsibility of the midwife within the clinical environment. Midwives are suggested to be more autonomous within the midwifery led unit (as opposed to the consultant led setting). However, this autonomy and the responsibility that comes with it, is argued to be a challenge for some midwives. This led me to question my prior assumptions that all midwives working within a midwifery led unit were autonomous and confident in working within that particular birth environment. In the second quote, reference is

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made to perceptions of time, and being 'up to speed'. This reduction in speed was interpreted as a lack in confidence or skill. The concept of time will now be explored.

8.3 The concept of time in midwifery

The concept of 'time' is central to midwifery practice, and may be explored through various paradigms. In this context, it appears that time can be given or time can be restricted. Both aspects are reflected in the following three quotes;

'Cause I firmly believe that is one reason that we've had a good caesarean section rate because we we're comparatively well staffed so we could give women a 1-1 (1-1 support), care and that helped them through and because it's easier, it's quicker to section somebody ... And work, sometimes you work a lot harder for a normal delivery like you say and sometimes somebody is 3, 3 hours in the second stage, (yeah) you know, whereas where you can just go the theatre and half an hour later (it's done in 40 minutes) yeah (its, that's one less to worry about). It is definitely a time thing as well isn't' it. If it's that busy you don't want a woman staying on labour ward do you for how many hours. Pressures are on to get her delivered and up. (GI CLU A)

'But I think it's also facilitating normal birth, is recognising, yeah things might be progressing, progressing slowly ,but they're still progressing and not having any strict time limits "oh you can only push for then" or "you can only do this". (GI CLU A)

'[Thinking of this expert, what do you feel that you would like to learn from her] *Patience. (pause). Patience. Allowing a woman to do the job. Yeah. Rather than 'lets get this woman out of here, delivered and so on'. She will facilitate the woman, be quite patient, and allow the woman to do it herself'.* (II CLU B)

In the first quote, participants acknowledged that giving women their time (one to one labour support) facilitated normal birth and positive birth outcomes. However, participants identified the pressures midwives faced to 'get women delivered'. This often resulted in midwives or doctors intervening in order to 'speed up' the labour process, thus taking time away from women. This theme is reiterated in the second quote where participants suggest that the length of labour may be restricted by the time limits set on labour. The final quote suggests that one characteristic of expert practice is the ability to be patient. Thus, experts were reported to be patient, allowing the woman time to labour and birth.

This patience may be argued to derive from the expert's fundamental trust and belief

in normal childbirth, and in their ability to give their time to women. In other words, experts spent time listening to women, and regarded 'listening' an important aspect of expert practice. Experts also valued the importance of building relationships with women and their families.

The importance of 'listening' is also supported in the research literature (Tofias 1989; Shallow 2001). Thus the expert is not only able to 'listen' to women, but she is also able to really 'hear' what she is saying. Therefore, the experts approach to care is fundamentally based on the needs and wishes of the individual woman. Thus experts valued empowerment and support, and were highly skilled in their ability to provide a balance between the two.

However, participants in this study recognised that time and staffing pressures affected midwifery practices. They noted that they were often unable to provide one to one care, or give basic labour support. This made establishing meaningful relationships with women difficult, and resulted in midwives feeling dissatisfied and frustrated with the care that they gave. This stress, burnout, and low morale, have been reported as main reasons for ceasing to practice (Sandall 1997; Curtis et al 2006).

In many maternity units, an integrated team approach to midwifery has been implemented in an attempt to integrate the hospital and community ways of working. This often requires midwives to work in both community and hospital settings on a daily / shift basis. However, midwives often reported difficulty practising a 'with woman' philosophy in an institutional context (MacFarlane & Downe 1999; Hunter 2004). This was also evident in this current study and can be demonstrated by the following two quotes;

[response to question, do you think the expert midwife (independent midwife) would practice the same in a hospital environment?] *'You can't really practise the same. Because you have got the constraints of the hospital... but also, if it's busy on the labour ward, and the community midwifes' looking after someone under midwifery led care, what they do is, because its just round from the labour ward, is that they move that woman from that room into a delivery room. Where then there seems to be a higher chance of intervention. Being on a labour ward. Because the midwife*

who is on community will look after that woman, but also takes over someone else's care as well. So unfortunately that woman's not getting that individualised care. Where as, going back to being an independent midwife, you do have more time. (Laughs) I'm sure that they could probably argue that they don't, but they do have more individual time with the woman. Without the constraints of the hospital, putting different hats on'. (II CLU A)

"you have got a lady in the delivery suite, you might also have something else going on or you're helping someone else (yeah), so you haven't got that sort of same time (yeah) to give the woman to explain coping strategies (yeah), or to you know really see her through it because obviously you've got all the demands 'cos you're working in a consultant unit where there's other things going on. That's what I find". (GI CLU B)

In another study conducted by Hughes and colleagues (2002), staffing levels, working relationships and organisational issues were reported to affect midwifery practice and morale. It was identified that midwives felt un-supported, especially in times of crisis. The lack of support compounded by staff shortages and high workload is evident in the following quote from the current study;

'And also there's a support, there's a support for other midwives' 'cause you weren't looking after 2 or 3 women,... erm you know like you had your 1-1 care so that other midwife "oh just come and have a quick look", they had the time to do it, not "oh hang on I haven't got time to do it". But now they're ringing round for staff who are looking after 2 or 3 women themselves, the leaders of the wards....' (GI CLU A)

In a recent paper by Curtis and colleagues (2006) entitled *'why do midwives' leave? (not) being the kind of midwife you want to be'*, it was concluded that staff shortages, not being able to provide that type of care that they wished, and the inability to develop meaningful relationships with clients were the main reasons for midwives' ceasing to practice. Evidence also suggests that newly qualified midwives are disillusioned by the realities of a maternity service which is often short staffed and medically led (Frazer 1999).

The majority of the findings in the above studies were echoed within the group interviews in this study. Disharmony in working relationships was identified due to perceived differing philosophies and priorities between midwives';

" I think there is a bit of a culture where if you're in a room with a woman and you don't come out it's like you don't want to work, you want to, shirk away from it you don't you know you don't want to be doing anything else and you're a shirker and it's not it's because you're in there supporting that woman and there might not be anything else that you're needed for going on outside but it can be perceived like that so I think there is erm the way work is organised it's almost like "well you're having that lady, but we do expect to see you so you can answer the door bell, you can answer the phone, you can see what's going on", so if it was "this is your lady and we will come and get you if we need you", rather than "this is your lady but we don't expect you to shy, in those closed doors, hiding away from us" (laughing) it might be better attitude". (GI CLU B)

Thus, some midwives felt pressured to be seen to 'be doing' as opposed to 'being with' women in labour. Findings in this current study suggest that standing back and doing nothing may be perceived as laziness. This is reflected by the following two quotes presented by the same participant;

'Because I had a midwife on community once, and I went to a home birth. And she did nothing, she just sat there. And I wish she'd have said to me, "what I'm doing now, is I'm just observing how she's behaving" but she never actually said that.....Because being an ignorant student at times, you see a practice and think "that's laziness that, really, she's just sat doing nothing" (laughs),...So its good for the midwife to tell you what she's doing, because sometimes it does look like they're not doing much. But you hear that the best midwives' are the ones that sit on their hands, and do nothing'. (II CLU A)

'I thought she didn't do anything. I thought "is this all you do?" you just sit down and just watch people. And then when I looked deeper into it, she was observing how the woman was behaving, erm and looking at all the primal instincts, and not just listening in every 15 minutes like you do in the hospital, and I found that really interesting'. (II CLU A)

However, in fact, this ability to do nothing was regarded a fundamental characteristic of expert practice. This concept will be explored in the next chapter.

8.4 Influences of prior experiences on midwives' values and beliefs

The different values and beliefs placed on birth were suggested to be influenced by prior experiences;

"And I think that when people come from a busy consultant type unit... and we have all, and we all have done. It does take a while to change the ways you do things and the ways you look at things, and accept the norm in a way. Because you do always have that back up don't you. And you were, we were all community

midwives before we came here [midwifery led unit], so I think that puts you in a kind of good stead really for working in a unit like this. You have to think very much on your own out there don't you. You don't have that where you can nip out and get somebody in the sluice and have a quick conflab. You don't. It's very much what you are doing and you have to come in and consult with someone... em .. (pause). It used to be one midwife for a delivery didn't it. You know, that was how we did it... there was never any back up, even in the home. There was only one midwife... and I think that really does open your eyes to you have to trust what is happening with the woman and I think that is something I have found..... that when people sometimes come from other unit, a busy unit, it does take a while to get out of that consultant mode. Em I'm not saying that everybody, but some people... even after years.... It's still there.... And I don't think it will go...' (GI MLU C)

This quote demonstrates how prior experiences, confidence, and the underpinning philosophy of a unit, or philosophy of care has on individual midwives' practice, and on the trust and belief in normal birth. These different philosophies were also suggested to influence birth outcomes;

"When it's in a setting like this [MLU] I think all the different qualities and personalities that are here I mean no two of us are alike are we? We've all got different qualities. And even working together you get different (yeah) peoples don't you can, some people bounce of one another better than others".. "If you put two say midwives' on together they'll end up down the road. (laughter) won't they [being transferred from the MLU to the consultant unit". (GI MLU D)

This quote suggests that it is both the skills and belief in normal birth that is essential when working in a midwifery led unit. Participants suggest that if two midwives lack confidence (in either skill or trust in normal birth), then the woman is more likely to be transferred into hospital. This suggests that the attitudes and beliefs of midwives can have a direct influence on birth outcomes;

'Where if you've a problem you know if you're working with one person, that they will, that that problem will immediately be transferred, without every trying anything else first. And when you're working with others you know that you can jiggle things round. ALL within the safety, I'm not saying that either aren't safe, It's just that some don't feel comfortable with the challenge at all' (II MLU D)

There appears to be current interest in the attitude of midwives. Butler (2007) identified that having 'the right' attitude was an essential characteristic determining competence at the point of midwifery registration. Emphasis was placed on being

motivated, being enthusiastic, committed to women and their families, being kind and compassionate.

However, it appears that the term 'attitude' is a new phenomenon to the nature of expertise that was not evident in the literature review (Downe et al 2007). This concept appears to be significant in so far as it may predict or influence birth outcomes. This will be explored in the following chapter.

Midwives in the group interviews recognised that the fear of litigation had a significant influence on midwives' individual practices and on the culture of midwifery in general;

"The thing is we're so conscious of litigation as well and that sometimes not done us any favours, Because you're watching your back all the time and that's very, very difficult in the profession and that, that's maybe that's inline with what you said (mentions participants' name), because the midwives are frightened that if they don't do that and something happens, you know it's their profession" (GI CLU B)

Midwives emphasised that this fear of litigation placed pressure on midwives' to conform to routine practices. The following discussion is between two midwives' in the group interview;

MW1 "the policy is that we have this erm (admission) admission trace"
MW2"(yeah) but then you can chuck your monitor in the back room and manage everybody normally".
MW1 "Yeah but only for, only for ... 2 hours and then you've got to put them back on it again (on that labour ward) got to put her back on the monitor [people question] (what's you're monitoring like? I've not had her on a monitor. Why've you not had her on a monitor? Well".
MW2"...But that's what I mean, that's, it means that it's you as an individual, [practitioner] like you say if you go out of the door (hmm) you start practising differently, which is, I mean I know cos I've just I've been there as well and you have to be very strong minded... You just shut the door."
(GI CLU A)

It is evident here that the group dynamics and group interaction have influenced the data. The discussion indicates that midwives require strength to be able to challenge cultural or practical norms, and to promote normality within a hospital environment. However, this is not a simple relationship. As a result, participants suggested that midwives were often forced to adapt their practice to suit the clinical environment,

and the two apparent opposing philosophies within those environments. This is represented by the phrase *'putting different hats on'. (II CLU A)* and is reflected in the following quote;

"I think sometimes you do (you do) because you follow what (exactly) your colleagues are doing cos today you're a labour ward midwife (exactly) tomorrow I'm a community midwife" (GI CLU A)

A recent paper by Hollins Martin (2006), suggests that higher status midwives exert more power and control than junior midwives, and thus may have a profound effect on care. Examples given included whether or not a woman would be 'allowed' a water birth. Hollins Martin (2006) suggests that this would present more junior midwives with a moral conflict between a desire to be obedient to authority and in their role as advocate to the woman.

8.5 Reaction to the context of childbirth

Within this part of the chapter aspects of 'the nature of normality', 'midwifery interventions vs. medical interventions', 'Professional projects of birth' 'midwifery professional projects of birth' and 'the midwives personal project of birth' will be addressed as it may be argued that the above factors may influence or determine the culture of childbirth, which consequently affects midwives' practices, and the meaning of intrapartum expertise.

8.6 The nature of normality

Issues surrounding the definition and nature of normal childbirth have been previously addressed in chapter two. It may be assumed that a reduction in normal birth will consequently affect the development of expertise in this area. As midwives claim to be the experts in normal childbirth, it is for this reason that the nature of normality is given an overview here.

Participants in this study suggested that a wide range of definitions of normality exist, each being influenced by personal values, beliefs, culture and expectations. It was suggested that the philosophy of the wider midwifery culture influenced midwives' perceptions of normal birth

"I think as midwives we are sort of (pause) programmed to believe that a normal birth is, spontaneous labour, no intervention and nice vaginal delivery (yeah), that's what we see as normal. But I think that is just our culture that leads us to believe that (yeah), that normal means no intervention" (GI CLU A)

The terms 'normal' and 'the norm' were often used by participants interchangeably to describe the same phenomena. There appeared to be conflict as to the use of these terms, and in defining normal birth. Generally speaking, midwives held the belief that normal meant spontaneous and non-intervention:

"From, my perspective I look at it as like we were saying before spontaneous onset erm and no interventions" (GI CLU A)

However, it appeared that normal birth was often defined negatively by the absence of intervention. This is reflected in the following three quotes;

"I mean a normal, Normal birth to me means spontaneous labour, that's a normal birth... Spontaneous labour, yeah. Most will fit, fitted criteria again won't they. And who's to say that it's right? You know sometimes.... There is intervention when there doesn't need to be, in lots of cases. ." (GI MLU C)

"Without medical intervention. (Yeah I was going to say that). I suppose the way nature intended it, as mother nature intended" (GI CLU B)

[defining normal birth] *"Without interference....Without intervention (yeah) that's the normal process...Just how we like it (laughter)".* (GI MLU D)

However, there was much debate about which interventions were acceptable within normal birth. Midwives in the group interviews described a continuum of normality, a scale which transcended from one end of the spectrum where labour is spontaneous without the use of intervention, to the opposite end of the scale where a vaginal birth results, regardless of interventions used during the labour;

"And who's to say what's normal anyway, because normal's from here to here isn't it? [Uses hand gestures] (Yeah, yeah). .... that's what I say the word normal in inverted commas, covers a multitude of sins doesn't' it." (GI CLU A)

"But to me it can also be with intervention it can be with epidurals and it can be with you know with syntocinon and augmentation and things because they still have a normal birth don't they - to me?" (GI CLU A)

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Thus there appears to be conflict in opinions regarding the definition of normal birth, and interventions acceptable within the boundaries of normality. Some participants placed emphasis on the 'birth' or 'mode of delivery' as significant in its definition. This is reflected in the following two quotes;

"..we all talk to women, they come home and you say you know how did you deliver "oh, I delivered the baby myself", oh you had a normal delivery that's wonderful, you did such a good job and the possibility of them having had an epidural or pethidine or whatever, well that goes out the window, it no longer has any importance the 'normal delivery' was just that final act (hmm), and that takes you away (yeah) from what normal birth is about." ....I think there's also a blurring of boundaries between normal and abnormal isn't there and that's where (yeah) a lot of the difficulties lie (hmm)" (GI CLU B)

"It, it, it is a cultural thing now, they expect (they expect it), (hmm). And they don't, they won't tolerate any discomfort, no matter what it is. Which is fine, I'm not saying that's wrong, of course it isn't, why suffer if you don't need to but align with that, they want their baby on that day as also, so when we then intervene because they insist on erm you know having their induction, then the rate of failure is , is high and we end up with a lot of intervention don't we?" (GI CLU B)

Participants again focused on the delivery as the factor determining normal birth, whilst events during labour were not taken into consideration. They also acknowledged that midwives' perceptions of birth often differed to the perception and experience reported by women. This is reflected by the following quote;

Mw1 "But your gut feeling is that an epidural isn't natural 'cause it's not a normal intervention is it? But gas and air is, is OK.
Mw2...But then a woman who's just had gas and air might think that's absolutely awful or traumatic (yeah) and not normal at all .....But she's had an epidural with vaginal delivery and thought it was perfectly normal" (GI MLU D)

Here, the participant acknowledges that women may not perceive a natural labour (without pain relief) as normal, and in some cases, women may be traumatised by the experience. This leads to consideration of the detrimental effect to women's psychological or psychosocial health that may result if the woman and midwife have different aspirations or expectations from birth. Thus, it appears that expert practice may be characterised by the ability to provide individualised care for women regardless of midwives' own personal philosophy or beliefs about childbirth. This aspect will be discussed later in the chapter under the subheading 'midwives'

professional project of birth' (Page 76).

8.7 Midwifery interventions vs. medical interventions

Mead & Kornbert (2004) argue, *'variations in intrapartum care cannot be solely explained by the characteristics of the women. The influences of a workplace culture play a significant role in shaping midwives' perception of risk'* (p61).

In this current study, midwives in all four units appeared to attribute different values and meanings to intervention in labour. This appeared to be dependent upon whether the interventions were carried out by midwives or doctors, and did not appear to take into consideration the woman's perspective;

"Well we tend to look at normal birth as not being a forceps or ventouse don't we, that is our (definition) cultural definition of normal". (GI CLU A)

"I think most definitely once the doctor delivers that is (laughing) not acceptable (more laughter). Once they've started using ventouse' and forceps and scalpels that's most definitely not a normal birth" (GI CLU B)

Participants in this study generally argued that interventions that were able to be performed by a midwife were acceptable within the boundaries of normal birth. However, interventions were argued to be acceptable only if they were justifiable in terms of benefiting the woman and reducing the need for further interventions. These issues are reflected in the following three quotes;

"Is it not because we can actually do that interference, so that's why it's acceptable?" (GI MLU D)

"Things that will reduce medical intervention are on the boundaries of acceptable (yeah, yeah. (yeah, yeah). The midwives' can intervene without asking anything else of the medical staff." (GI CLU B)

"I think only if we do have a reason, have a purpose (hmm)" (GI MLU D)

However, there appeared to be much debate between participants surrounding which interventions were acceptable within the boundaries of normality;

"It's really difficult isn't it I mean ARM, sometimes we do it at full dilatation when their bulging at the vulva probably not necessary but we sometimes do it and I

don't think that really classes it as being truly abnormal, erm" (GI CLU B)

'It's really (very tricky) (pause) like cervical sweeps are not normal are they? (yeah). Mother Nature wouldn't do a cervical sweep though it's going to prove beneficial" (GI CLU B)

"I suppose its things like the sweep we're intervening then aren't we, when we do ... sweeps, we do accept that. cause it seems more natural (yeah). Because it seems more natural and a way of getting the woman into, to you know into spontaneous labour and rupturing membranes although we rarely do it, that, that's an interference isn't it but you see it as the lesser of the two evils". (GI MLU D)

As highlighted by the quotes above, there appears to be three evident arguments, the first argument being what constitutes an intervention, the second being which of those interventions are acceptable within normality, and the third being how these two are mediated by the professional who carries out the intervention. Participants generally considered anything that altered the natural process of labour an intervention unless it was carried out to prevent a perceived more traumatic intervention. Some of the examples given in this study included induction of labour, various forms of analgesia (TENS, entonox, pethidine, epidural), methods of augmentation, and episiotomy. Midwifery care itself was also argued to be an intervention by some participants.

Participants also reported occasions when experts would use interventions in order to protect the women against the time constraints of labour and protect them from further medical intervention. Examples included performing artificial rupture of membranes, and more invasive interventions including manual rotation of the fetal head;

'One of the midwives' (names expert) she's really good. If say, you are struggling and it's been over two hours of pushing whatever, she can come in and she'll try with her fingers to rotate the head to bring the head down. She's worked there thirty odd years, you know her skill is just, she's very calm, again, calm. And but then she knows if it's not going to come out. She'll know when to get the doctor... she's also an expert in normality. Because she's saved if you like, a lot of women from having a caesarean. ..And she gets babies out, or (pause) women in positions that helps to get the baby out.' (II CLU A)

Midwives referred to these interventions as 'the lesser of two evils', suggesting that many midwives used interventions cautiously or reluctantly in order to protect women

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from further medical intervention. Thus practitioners would often use interventions that they would not usually support, in order to protect women from further technical or medical interventions. We first identified this as 'ironic intervention' (based on the work of Annendale 1998) in the published literature review (Downe et al 2007). However, participants in this study reported the act of deliberately 'not intervening' as being more significant in promoting normal birth, and protecting women against medical intervention. This was illustrated through the performance, or rather the non-performance of vaginal examinations, especially if the midwife suspected the woman was approaching full dilatation or was fully dilated;

"...don't confirm them fully... yes. Because I think that is something every midwife does. If you think they are coming up to fully, don't VE them, don't have that knowledge, that you have to write it in your notes. And then you have got leeway haven't you. Who knows when someone is fully dilated? Who are we to say she's been fully for three hours, we don't know that unless we have confirmed she's fully dilated. She could have been fully for an hour already. It's only speculation isn't it. And I think this is one of the things (laugh) that some midwives do. MOST midwives, I would say do. Because it is giving you extra time to achieve the norm"
(GI MLU C)

Participants in MLU D also reported that they were unlikely to report findings of full dilatation of the cervical os, as confirming full dilation would limit the length of the second stage, and therefore increase the chance of interventions. This discussion took place after the tape recorder was switched off. Participants agreed to the documentation of field notes during this discussion. It appears evident that by having the knowledge, or information on vaginal examination findings, midwives have to act on them. So by not undertaking the vaginal examination in the first place, midwives may be argued to protect women from the time constraints of the second stage.

In a study conducted by Hunter (2005), *'junior midwives were observed to subtly manipulate information to keep senior midwives happy, while practising in a way that was congruent with their own beliefs regarding natural, woman centred childbirth* (p261). Covert tactics such as underestimating cervical dilatation were used in order to give women more time. It may be assumed that these covert tactics were used as a way of promoting normality, and whilst appearing to comply and work with the

medical system, they were in fact challenging it. This appears to be an important paradox, and appears to echo what Davis-Floyd (2001) has termed post-modern or hybrid midwifery. Post-modern midwives are suggested to be able to move fluidly between their own belief system and the biomedical system, negotiating or subverting the medical system in order to provide woman centred care (Davis-Floyd 2001). It may be that this ability to negotiate or overcome these challenges is an important characteristic of expert practice.

8.8 Professional projects of birth

It may be argued that the culture of the birth environment may be shaped or influenced by the individual philosophies and practice of midwives being cascaded throughout the workplace. This can have both a positive or negative effect on the culture of the birth environment. This personal or individual philosophy may be regarded as the 'midwives' personal project of birth'. The collective culture of midwifery can then be described as 'the midwifery professional project of birth'. Both of these terms will be explored in the following section.

8.9 Midwifery professional project of birth

It is widely accepted that each discipline has its own unique ideology and body of expertise (Reime et al 2004). Gavin (1997) argues that Western society is dominated by professionalism, with each occupation making its unique contribution, competing for power, influence, wealth and status. The term 'professional project' refers to a profession's attempt to gain control over their arena of expertise, encompassing the ideologies, social representation and actions that shape an occupation (Witz 1992; MacDonald 1995; Gavin 1997; Henriksson et al 2006).

The midwifery professional viewpoint has evolved over time, being influenced by individual perception, beliefs and experiences. As discussed earlier, midwives are en-cultured to believe that normal birth is spontaneous, without the use of interventions. This could be regarded as fundamental to the midwifery professional project of birth. However, it must be acknowledged that some midwives willingly accept both

'midwifery' and 'technological' interventions in childbirth (Crabtree 2004; Mead and Kornbert 2004; El-Nemer et al 2005). However, this may be argued to challenge both the legitimacy of midwifery, and the nature of midwifery expertise.

Participants in this study alluded to their responsibility as midwives, to 'protect' women against unnecessary medical intervention;

"I mean I was outraged on Monday night...I'd gone back into her [woman in labour] *and a doctor had been in earlier because we were a bit concerned about the trace, so I went back in to her and she says " oh* (mentions participants name)*", she says "what did the doctor say about that internal?" I said "what you talking about?" And she says "the doctor's just been in and examined me" (oh). So I was straight on that phone "what you doing?" you know "Why are you interfering?" We had a bit of a row actually (laughter).* (GI CLU B)

However, this quote may be interpreted in two ways. Taking one perspective, it may be argued that the midwife is challenging the doctor's intervention in order to promote normality and protect the woman from further interventions. Taking a different perspective, it may be argued that the quote depicts the midwives' struggle for power and control against the medical profession. In other words, did this particular midwife confront the doctor because the doctor challenged the midwives' decisions and thus their knowledge and expertise, or because the intervention may have influenced the outcomes for the woman? Is this about the 'woman' or inter-professional 'jockeying' about power and control, and the strive to promote the midwifery professional project of birth?

Participants in the study identified a cultural shift in the midwifery professional project of birth. This is demonstrated by the following quote;

"Who was it that when they first came here used to apologise because there was a lady that was actually on the bed delivering and she apologised she said "it, it, it was her choice,(laughter) I didn't make her do it"... I think we do more of that now don't we (yeah), since we've gone midwifery led really. (Yeah, yeah). So I suppose there's in a way another pressure in other ways isn't it, instead of, you know without medicalisation of (yes I think that), childbirth and now you've sort of gone the other way you do feel you have to apologise if somebody's not in the pool or they're not standing or whatever." (GI MLU D)

This quote suggests there appears to be pressure placed on midwives to adhere to the professional project of birth, to promote normality within the clinical environment. However, there were instances reported when conflict of interest occurred between the ideals of the midwifery professional project of birth and individual women's choices. This is reflected by the following quote

'The importance we place on normality may well be in a way at the expense of the women's psychological perception of their labours, because we like them to have a normal delivery don't we? (yeah). And sometimes I think they, they're not bothered whether they have a normal delivery or not they just, (they just want the pain to stop) they just want the baby out safely and the pain to stop... And, and does it really matter? (hmm)'. (GI CLU A)

This quote demonstrates how the midwifery professional project can work against the ideals and expectations of women. Thus, if all women have different beliefs and expectations of labour, then it must be essential for the midwife to first uncover these needs to enable her to give appropriate care.

8.10 Midwives' individual personal project of birth

Participants in this study suggested that the personal beliefs or philosophies of individual midwives' fundamentally influenced their perceptions of, and use of interventions in labour. Thus, midwives' individual philosophies and values contribute to the midwives' personal project of birth. Individual or personal projects of birth may be situated anywhere on the 'normality continuum' as discussed previously. The following two quotes present how the individual midwives' philosophy based fundamentally on a lack of confidence and distrust in birth may affect her practice and therefore birth outcomes;

"There is a midwife in particular that I can think of, who (pause) I can honestly say she does a lot of things like episiotomies, and her students that see that happening are now qualified. And I see them doing it, and I just think, but why? I can count on one hand how many I've done. Whereas because they have seen how that midwife is. Like the epidural rate when that midwife is on is like 100%, with the women she has. Because her personal belief is that you shouldn't go through you know, any pain. So then they end up with either caesarean, or episiotomies or whatever. And if a student sees that, if that's all they know throughout their training, then how can they think, oh lets take them off the monitor, let's get them up walking about. And then they'd probably think what's going to happen if I take

this monitor off, what if something happens and it's not on". (II CLU A)

In contrast, a midwife who overtly promotes normality without taking the woman's choices or preferences into consideration may also have a detrimental effect on the physical or psychological health of the mother;

"Do you think we have some sort of "oh well I managed to get a normal delivery, so haven't I done well", but for the woman it might have been the most horrendous experience that she's ever had and yet we're patting ourselves on the back saying "yeah but she had a normal delivery, aren't we good"..(yeah, yeah)" (GI CLU A)

There appears to be a fine line between the drivers of the midwifery professional project of birth, the midwives' personal project of birth, and women's choice. Midwives must provide a balance so that the strive for normality is not detrimental to the woman's well being. Thus, there is a need for midwives to be reflexive, to constantly challenge their prior assumptions and practices, in order to ensure that their own personal beliefs do not have a detrimental effect on women's experiences, or outcomes of birth.

8.11 Summary

Participants in this study reported that midwives face pressure from a variety of sources, which affect their every day practices. These included time pressures (time restrictions placed on the length of labour and not being able to give women their time due to staffing or workload pressures), fear of litigation, and a pressure to facilitate women's choices and needs. This has been argued to influence both the workplace culture, and more widely the culture of midwifery.

Findings from this study suggest that professional projects (both the 'midwives' personal project of birth' and the 'midwifery professional project of birth') significantly affect and influence both the culture of midwifery and midwifery practices. Findings suggest that the pressure to meet professional ideals may cause conflict for midwives when providing and facilitating women's choices. The findings of this study suggest that the ability to provide this balance is an important characteristic of expert practice. This issue will be addressed in the following chapter.

Findings from this study suggest that the concept of normal birth is important for intrapartum midwifery expertise, but remains unclear for the group of midwives in this study. While some participants argued normal birth was defined by the absence of interventions, others argued that interventions that could be performed by the midwife, which would benefit the woman by reducing further medical intervention, were acceptable within the boundaries of normality. In contrast, some participants argued that normal birth could be defined by a vaginal birth without ventouse or forceps. Interventions used during the labour were not taken into consideration. Thus, there appears to be much debate and confusion surrounding the nature of, and practice of, normal birth.

This leads to question as to whether in fact midwives can claim to be the experts in normal childbirth. Furthermore, if midwives can justify this claim, they must demonstrate that they can retain the skills necessary to facilitate normal birth.

The following chapters will address how midwives deemed expert by their colleagues, are able to challenge or negotiate the cultural and practical problems highlighted in this chapter, and identify the skills, practices and beliefs required for expert practice.

9.0 Findings chapter 2: Wisdom

9.1 Introduction

The overarching theme of wisdom has been used to incorporate the codes knowledge, education, experience, and personal attributes. Although aspects of the first three codes were evident in the review (Downe et al 2007), the code 'personal attributes' appeared to be a new finding to the theme wisdom.

Although the concept of wisdom has been explored by various researchers (Tritten 1992; Lauder 1994; Litchfield 1999), an agreed definition does not yet exist (Ardelt 2004). Ardelt (2004) proposes a three-dimensional personality characteristic of wisdom (Cognitive, reflective and affective), based on her prior work (Ardelt 1997; 2003) and that of Clayton and Birren (1980). In her description, she quotes;

'the cognitive dimension of wisdom refers to the desire to know the truth and attain a deeper understanding of life......the reflective component of wisdom represents self-examination, self-awareness, self-insight and the ability to look at the phenomena and events from different perspectives.....and finally the affective component consists of a person's sympathetic and compassionate love for others" (Ardelt 2004, p275).

In the current study, three codes ('knowledge', 'education' and 'experience') were suggested to encompass the meaning of wisdom. In addition to these codes, a fourth code, 'personal attributes', was added to capture the essence of the 'wise' individual. It may be argued that these support the three-dimensional personality characteristic component of wisdom as proposed by Ardelt (2004). The rationale for this is based on the assumption that wisdom cannot be limited to the intellectual or cognitive domain but encompasses the whole person (Ardelt 2004). In order to measure wisdom, it may be more important to find out what a person is like rather than what they know (Moody 1986). The desire to gain knowledge, the ability to learn from experience, and the ability to be motivated to seek new knowledge and experiences, appears to fit within the 'cognitive dimension of wisdom'. The ability to be reflective and reflexive in order to give individualised care to meet the individual needs of the woman and her family appears to fit within the 'reflective dimension of wisdom'. Finally, the ability to make connected relationships with women and colleagues founded on trust,

honesty and mutual respect appears to fit the 'affective component' of wisdom. This will be explored in subsequent chapters.

The following quote from our current study appears to represent what is meant by the concept 'wisdom';

"..And you learn a bit from each colleague (yes, oh yes). You sort of take a bit from each one don't you (that's right). You know, I always think I learnt from (mentions midwifes' name)... 'cos I remember when I first came and... she's a very gentle, laid back sort of person, who's retired now, erm being with her and somebody who was, erm in the second stage of labour and you'd think she was on a walk outside in the countryside on a sunny day sort of thing. And I sat on a stool for the first time in the labour ward and we just chatted... with the lady...I just learnt to be relaxed and not interfere, whereas prior to that it would be like the legs on our hips and give a good push... and she just undid that eighteen months, which was really good" (GI MLU D)

The above quote appears to echo the reflective and affective components of wisdom. Personal attributes such as 'gentle' and 'laid back' describe the characteristics of the expert. The expert is suggested to facilitate a calm relaxed environment, and establishes relationships with women through effective communication. The participant suggests that the experience of working with this expert changed and influenced her way of practising. Thus, expertise may be regarded as the ability to be seductive in its ability to change and influence practice. The phrase *'and she just undid that eighteen months'* appears to be a powerful statement as it suggests that midwives' routine practices can be challenged and changed by observing expert practice. Therefore, expert practice may be a powerful effective way of changing maternity care. These issues will be explored further in the following section.

9.2 Knowledge and Experience

Though separated in the literature review, the two themes 'knowledge' and 'experience' will be presented together as it was impossible to separate them in the phenomenological data.

Eraut (1994) identified two facets of knowledge, 'knowing that' and 'knowing how'. 'Knowing that' refers to a fundamental knowledge base or theory, and 'knowing how'

refs to being able to do the job. Eraut suggests professional knowledge integrates the two and, together with a unique understanding of the individual patient, determines expertise (Downe et al 2007).

Ardelt (2004) argues *'intellectual or theoretical knowledge is knowledge that is understood only at the intellectual level, whereas wisdom is understood at the experiential level. It is only when the individual realises (i.e. experiences) the truth of this preserved knowledge that the knowledge is re-transformed into wisdom and makes the person wise(r)'* (p260).

Findings from this study suggested that expert midwives fundamentally possess a sound knowledge base that is continuously being updated through ongoing education and research. This is reflected by the following two quotes from the current study:

'And I think that furthering your study should help your practice. Because it keeps you up to date. It keeps your grey matter going. Erm, I think if you just rested on your laurels, and did nothing else, you could get really set in a routine. And it might not be the right routine for that woman'. (II CLU A)

"...if you're motivated enough to keep yourself up to date, to read the literature to pursue, you know research based evidence based practice and be involved in research then you are more likely to have a wider knowledge and that's how you become an expert because you've, you've gained the knowledge and the experience, the two go hand in hand......Yeah with the experience you can't say one without the other could you because you could read a 100,000 books couldn't (yeah) you and be really academic..." (GI CLU A)

Both quotes emphasise the importance of updating knowledge in order to stimulate mental ability *'keep your grey matter going'*. It appears to be the motivation or desire to learn that differentiates the expert from non-expert. Kennedy (2000) revealed similar findings in her study where 'experts' demonstrated 'intellectual curiosity' as they continuously searched for educational opportunities. However, as the second quote suggests, expertise appears to derive from something more than possessing knowledge or having experience. Kennedy (1987) argues that although expertise evolves and develops with experience, *'expertise can not be assumed to develop automatically through years of service'* (p175)

This is supported by the findings in this research and demonstrated in the following two quotes;

"I think.....no offence to some of the newly qualified midwives, no they are not experts, no they are not experts as they have not got the quality of experience. That comes and it comes sooner or later doesn't it......you don't have to have 20 years to be an expert...." (GI MLU C)

"And equally we've had midwives who've been in this unit 25 years who you wouldn't consider experts..." (GI CLU A)

In the first quote, the midwife makes reference to the importance of the 'quality of experience' as opposed to the length of experience. In other words, there appears to be no set time limit in which expertise develops. Thus, it may be argued that in time all midwives' will gain expertise through experience. However, the second quote argues that length of experience does not determine expert practice. It appears evident from the data that the quality of the experience facilitates expert practice. In this context, quality refers to the diversity of the experience, and how this is internalised;

"..Well they can have the experience, but it's knowing what to do with it, it's a learning product isn't it (yes). I mean you can have years and years..." (GI MLU D)

'She's used her experience. She's USED everything that she has gained. And has tried to turn it into, turned it round and used it all the time. She doesn't just coast along'. (II MLU D)

Thus, if midwives encounter the same repeated experiences and do not seek new experiences, they will not facilitate expert practice. Both quotes identify the importance of 'learning' from the experience as opposed to simply encountering the experience. The second quote suggests that the ability to 'use' or 'learn' from their experience denotes expertise. In this quote, the participant suggests that the expert 'does not coast along', indicating the expert's motivation and commitment to learn. Ang (2002) supports this claim by proposing *'the progression from novice to expert nurse depends on the ability to learn from experience and to apply the knowledge when faced with a similar situation'* (p493). Benner (1984) suggests that experiences

require 'processing' in order to have an impact on future practice or behaviour. Thus, expertise derives from the practitioner's ability to examine and analyse performance, with the objective of refining practice (Benner 2001). In order for this to occur, experts are suggested to demonstrate the ability to be both reflective and reflexive in their practice.

The terms reflexivity and reflection are often used interchangeably in the literature (Lamb & Huttlinger 1989; Finlay 2002a). Finlay (2002a) suggests that reflection may be defined by the ability to contemplate a situation, usually after the event. In contrast, reflexivity *'taps into a more immediate, continuing dynamic, and subjective self-awareness'* (p532). In this current study, experts were argued to be both reflective and reflexive in their practice;

'One of the midwives' [regarded an expert by the participant] sent a woman home after she had a baby, I think it was after about two hours, she sent the woman and baby home because everything was fine. I think it was New Years Eve as well, but she had another child and she wanted to go home really...And then the baby ended up coming back, about two hours later, it was grunting and erm she said that the baby had turned blue. The baby ended up going to NICU, for a couple of days. But everything turned out fine. It must of just, I don't know what had happened, but this midwife discussed it with me, she said you know, I don't know whether I did the right thing there... I said that you shouldn't change your practice just 'cos of that one thing' (II CLU A)

This quote depicts the expert's ability to be reflective and reflexive through critical analysis of the situation and decisions made. This quote also suggests that experts are capable of making mistakes or errors in judgment. However it may be argued that the ability to be critical, reflective, and reflexive, denotes expert practice. Thus, through reflecting on experiences, a body of knowledge or expertise is created from which the midwife can draw (Price 1995).

9.3 Education

Eraut (1994) suggests that expertise derives from both experience and formal education. In both the review (Downe et al 2007) and the current study, there were little data relating to formal midwifery education. Although there is literature debating the significance of route of entry to nursing and midwifery (pre-registration or post-registration) with regards to confidence or competency (Alexander 1993;

Fleming & Milde 2000), this aspect did not appear spontaneously in the current study. This appears to be because education seemed to be taken for granted as a core requirement on which expertise would be built (Downe et al 2007). The ability to update knowledge through ongoing education was argued an essential characteristic of expert practice;

'Whereas a midwife who you think practice needs updating, perhaps, coz again, this midwife [defined by the participant as non-expert] hasn't got any other qualifications other than when she qualified. She's gone on in-house training and things, where as the midwives' that I was talking about before [those defined as expert],erm, I'm sure has at least her degree. And I think that furthering your study should help your practice. Because it keeps you up to date'. (II CLU A)

However, although the 'degree' itself was suggested to facilitate further learning and development, participants argued that possessing the qualification of the 'degree' itself, was not a pre-determining factor to the development of expertise;

"It is important that midwives do have ongoing education. And the degree is how we get into it really. How we move forward...."(GI MLU C)

"Do you need to have your degree?... no you don't. Looking at the midwives here for example, there are a few here who haven't continued, who are experts......but don't have the ability to pass that on quite the same..." (GI MLU C)

It may be argued that experts exist in the absence of academic qualifications. This appears to challenge the current culture of 'super-valuing' higher education. Thus the key factor appeared to be the ability to reflect on and integrate knowledge acquired through education and experience, rather than a formal qualification per say;

'It is very individual with the midwives, and it is how they are trained and how they are trained when they are a student. Not just by university, because there is a big gap between the way they teach and the way that is taught. But it is who you see when you are a student, who you see'. (II CLU A)

This quote suggests that both educational experience and clinical experience may influence the development and practice of individual practitioners. Reference is made to the theory practice gap which is evident in the literature (Upton 1999; Maben et al 2006). In the context of this quote, it appears that the gap is evident between the way

students are educated in the clinical and university setting. Although this aspect requires further exploration, data from the study suggest that individual midwives' practices may influence this gap. This is represented by the phrase 'who you see'. In other words, if a practising midwife is up to date with current research evidence, then her practice will echo that promoted by the university. In contrast, if a midwife does not update her knowledge, then students will observe practice which is outdated, which in turn may influence how students practice clinically. This will be explored in the following chapter.

9.4 Personal attributes

Barwise (1998) suggests that personality type cannot be ignored, each midwife having her own perceptions and experiences. In the current study, the following personal attributes, qualities or characteristics were proposed by participants to be characteristic of expert practice: calm and confident; advocacy; approachable; gentle; caring; good communicator; compassionate; kind; committed; enthusiastic; forward thinking; motivated; dynamic; friend, adaptable, flexible; and supportive. The most commonly described characteristic was the ability to be kind or caring to women and colleagues. This is reflected by the following two quotes;

'Erm, she's a very caring person. She's very sort of family orientated. She's very erm, yeah caring, and she cares about her colleagues as well as her patients. She's put out, you know she'll put herself out to look after her women. Erm, and she's very much erm, do the same for her colleagues' (II CLU B)

" She's retired. She had an excellent rapport in the community, with the people that still ask me now.. And she's been retired since 98,... and this is women, you know, some of them with kids in their 20's. ...., they still remember her, you know, ... You always felt confident working with her, she had the knowledge, she has... Everything that I think we've talked about today. She had it...... and I worked with her in the consultant unit.. Not here.. Not in this area... in a busy consultant unit...delivery suite.. And she was just the same. Protecting normality...She was a really lovely person...(yeah she was)... I couldn't imagine anybody not liking her. She was a friend to everybody. The women.... Students.. staff.. she had a good rapport with them... with everybody. ...She was wonderful". (GI MLU C)

Experts were frequently described by participants in this study as being calm and relaxed in their approach. This transferred to the woman and her family, facilitating a calm and comfortable birth environment;

'Well she's the ideal person, (yeah - laughs) isn't she, she's very calm, nothing phases her' (GI CLU A)

'And one reason [that defines her as an expert] is the relaxed atmosphere that you have when she is around, and the way she makes everybody feel relaxed, more than anything' (II CLU A)

In an apparent paradox, as well as being calm, experts were suggested to be dynamic and motivated, often doing things that were suggested beyond their call or duty. This is reflected in the following three quotes;

[the expert] *'will do things like go shopping and buy something for like the midwifery led care unit. She bought a leather settee, and she bought pictures. But she does all that in her own time. She doesn't do it, you know in work time. So, that is quite a big issue that'.* (II CLU A)

'I have to say (yeah) that's she's very, very caring [The expert]. *Will put herself on call when she's not on call...'* (GI CLU A)

'I think it's dedication. That's one thing isn't it? They are dedicated.' (II CLU A)

All three quotes suggest that the expert is dedicated or even devoted to midwifery. This appears to resonate with the concept of vocation. However it appears that the vocational ideal has been undermined by social and cultural change (Salvage 2004). The concept of vocation seems to have been lost in the drive towards advancing technology, while the art of caring continues to be dismissed (Wright 2004). Despite this, it may be argued that this is the true art of nursing and midwifery. It may be that as a midwife transcends through novice to expert, they re-value the art of vocation (Downe et al 2007). Although the concept of vocation has been explored further in the following chapter, its relevance to expertise requires further exploration in future studies.

In contrast to the positive characteristics suggested to be fundamental to expert practice, participants proposed characteristics that were deemed detrimental to practice. This is reflected in the following quote;

'Because they were very domineering and, and you know I didn't think they would treat me kindly. Not because I didn't think they knew their midwifery from a

theoretical point of view but I didn't think that they would be nice to me. It's back to the arts and science isn't it, the arts and science of midwifery it's not one or the other it's got to be both (hmm)'. (GI MLU D)

Again this quote highlights the art and skill of midwifery. It appears that the personal characteristics or attributes of the midwife is of equal significance to the competence and confidence that she displays. It is therefore the ability to integrate both the art and science of midwifery which distinguishes the expert midwife from the non expert. This theme will be explored in the following chapter.

9.5 Summary

This section has explored how knowledge, education, experience and the personal characteristics or attributes of the midwife are integrated to form the theme wisdom. Experts are suggested to be highly motivated and dynamic, constantly acquiring new knowledge and skills. As previously discussed, this aspect of expertise appears to fit within the cognitive dimension of wisdom as proposed by Ardelt (2004). The ability to reflect on and learn from experiences is consistent with the reflective aspect of wisdom (Ardelt 2004) and denotes expert practice. Finally, the affective component of wisdom is demonstrated through valuing the 'art' of midwifery. Thus emphasis is placed on caring and nurturing. Experts are suggested to demonstrate the ability to integrate the art and science of midwifery. The following chapter will explore aspects of skilled practice.

10.0 Findings chapter 3: Skilled Practice

10.1 Introduction

Benner (2001) proposes that in the acquisition and development of a skill, a person will progress through five levels of proficiency. She suggests that a person will begin as a novice, then progress through advanced beginner, through competence and proficiency, and finally become expert. However as Shallow (2001) notes; *'Expertise is not simply about performing a particular procedure or set of procedures quickly or efficiently'* (p237). Dreyfus (2004) argues that it is the ability to make refined, subtle decisions that discriminates the expert from the proficient performer. Experts demonstrate the ability to *'grasp the situation directly, recognize salient aspects, and ignore irrelevant ones'* (Shapiro 1998, 13).

Findings from this study have identified four codes that captured the meaning of what we have termed 'skilled practice';

1. Technical and fundamental midwifery skills
2. Confidence
3. Competence
4. Judgment and decision making skills.

Although many of these codes appear to be interlinked, each will be explored separately.

10.2 Technical and fundamental midwifery skills

Henderson (1969) described the truly excellent practitioner as *'one who has mastered the many technical skills and who uses her emotional and technical responses in a unique design that suits the particular needs of the person she serves'* (p76). Experts in the current study were suggested to possess both technical skills, and the more subtle skills of keeping birth normal. Both technical and fundamental midwifery skills were valued, transcending across the boundaries of normal and pathology. Generally, core midwives on delivery suite were regarded as the experts in high risk pregnancy, and were valued for their technical ability and their knowledge of complex situations;

'They are [core delivery suite midwives'] very skilled when things aren't going well and there are sort of pathological problems with the pregnancies that need intervention, they do have the expertise because they're here all the time they have a good deal of knowledge' (GI CLU B)

However, apart from this quote, there was little reference made to those midwives regarded as expert in high risk intrapartum care. Although it may be argued that midwifery skills may be regarded by society as inferior to technological knowledge (Woodward 1997), these subtle midwifery skills in fact appear to be fundamental in terms of facilitating positive birth outcomes and in the development of expert practice. This is reflected in the following quote;

'..Because anybody who can look after high-risk women. That's fine, they're midwives, but [they] *tend to become more obstetric nurses don't they. That's where I'm kind of coming from with it. So my expert would be somebody who can look after a normal labouring woman and facilitate her care, and facilitating her birthing her own baby in whatever setting. Whether it be in a high risk area, to keep as normal as possible, or whether it be perfectly low risk woman delivering at home'* (II CLU B)

Thus, participants suggested that the ability to master the fundamental skills appeared to be more significant than the ability to master the use of technology or equipment. Expertise was argued to be something more than possessing technical skills. This appears to resonate with findings from a recent paper published by Nicholls and Webb (2006) which explored what makes a good midwife. They conclude that *'a good midwife must be more than technically skilled in terms of physical care'* (p427).

This quote also identifies how the expert promotes normal birth in a variety of clinical settings. This requires the skill of adaptability. Furthermore, the ability to reflect on prior knowledge and experience enables the expert to facilitate normal birth through use of midwifery interventions;

'Keep her normal, be-with her. Encourage her, encourage the labour. Encourage the woman. Hands on, for comfort, and using all sorts of, well I suppose you can call them techniques. ..Using normal stuff to keep that labour normal. And getting the woman involved in herself, and promoting the woman's confidence, to be able to facilitate the birth, facilitates the labour. Facilitate birth .., so that the woman feels in control, so that actually the woman is doing the job. The midwife is just there to facilitate really and to help her'. (II CLU B)

However, experts were also suggested to be competent in emergency situations. Experts demonstrated the ability to use equipment, and were skilled in emergency procedures. Decision making was reflexive and spontaneous, and not dependant upon routine protocols or procedures;

'You know being able to be more adaptable. (pause). 'cause I do think you gain confidence through being adaptable I think don't you? It's trying things, and see if it works'. (II MLU D)

This requires the ability to utilise knowledge and experience, and demonstrate confidence and competence. These concepts will now be explored.

10.3 Confidence

Findings from the current study suggest that expert midwives are confident practitioners. However midwives recognised the importance of the expert not being overly confident or complacent. Experts were reported to demonstrate confidence or adaptability in their ability to work in any setting, being confident in making decisions, and displaying confidence in their ability to 'act' or 'not to act'. This is reflected in the following two quotes;

'I read somewhere that erm the definition of a good midwife is somebody who has good hands and knows when to sit on them (laughter, well, (yeah). But equally knows when to use them' (GI MLU D)

'Erm, and it is confidence, it is definitely down to confidence, having the confidence, just for, to be able to leave a woman without a monitor on, erm, to leave them, to experience the labour without intervening. To leave a woman without having to do a vaginal examination every four hours all the time. Erm, there's a skill there definitely. It's a lot to do with confidence' (II CLU A)

This confidence of 'acting' or 'not to act' was identified in the literature review and was referred to by Kennedy (2002) as 'the art of doing nothing well'. Thus midwives were confident in their ability to intervene when necessary, and demonstrated confidence when their decision entailed 'non intervention'. This is reflected in the following quote;

"...its doing these things rather than just getting other people involved too soon. And being happy, being confident with your own practice to say "well yeah we've

had some decelerations again on the monitor (and more) but we're happy to carry on because, you know otherwise everything looks fine", and I think your own expertise". (GI CLU A)

This quote demonstrates how the midwife is able to work with the woman's own body, in order to promote the normalcy of birth. It emphasises the importance of trust (in the normal birth process), confidence (in her ability to say everything is ok and challenge the time restrictions on length of labour), and knowledge (aware of the practices to promote the normalcy of birth). It also demonstrates the expert's ability to be confident in their decision making ability, and alludes to the ability to make judgements based on prior knowledge, experience and intuition. This will be explored further later on in the chapter.

Experts were also suggested to demonstrate confidence in their ability to take the lead or intervene if the situation arose;

'Supposing if something had gone wrong she would, if she was suspicious of anything she would just simply just have transferred her in'. (II CLU B)

In emergency situations experts demonstrated confidence in their ability to let others take the lead. This is reflected in the following two quotes;

'And I think that takes a lot of confidence [letting others take the lead] Erm, I mean yes you're obviously trusting your colleagues, to let them do that, she wouldn't do that if she didn't think we were. Confident to do it. But you've got to be comfortable in your own practice haven't you to do that. Because a lot of the stuff we do, we have to feel in control of to feel safe don't we'. (II MLU D)

'Coordinates. Coordinates. She's not always at the fore-front. She doesn't always charge in, get her sleeves rolled up and get on with it you know. No she just fits in everybody. Just yeah, coordinates' (II MLU D)

This quote suggests that experts demonstrated confidence and competence in their ability to take charge of emergency situations, but they did not necessarily have to display their expert ability.

10.4 Competence

Many of the findings in this current study appeared to transcend across both confidence and competence. Although the codes confidence and competence appeared to be a pre-requisite for each other, it was unclear whether the expert practitioner was expected to first display confidence in order to become competent, or vice versa. Although there is literature examining the nature of competence in nursing and midwifery, there is controversy surrounding its definition (Worth-Butler et al 1995). Newble (1992) simplifies competence as the *'mastery of the body of relevant knowledge and the acquisition of a range of relevant skills' (p226).*

Findings in this study suggested that expert midwives were able to recognise their own limitations, were able to work in any setting, and demonstrated competence in their ability to deal with the uncertainty and unpredictability of labour.

"That's the confidence and the competence (yes) and, 'cos you're not flapping (yeah) and not being panicky" (GI CLU B)

When exploring aspects of confidence and competence, participants generally used the terms simultaneously and interchangeably. Sookhoo & Biott (2002) suggest that handling uncertainty is a skill that matures with experience and is associated with confidence. We first identified this ability to deal with uncertainty in the prior literature review, and defined it as 'reflexive competence' (Downe et al 2007). Reflexive competence captures the expert's ability to make rapid decisions that were not dependant on standard protocols or routine techniques. It can be demonstrated in the following quote;

'It's hard to interpret what you see. I suppose isn't it. And, but she has [the expert], it seems to be, it's intuition isn't it. Knowing that something's not right. And the skill of maybe trying lots of different things and not just, be fixed in one pathway' (II MLU D)

Further exploration and conceptualisation of this aspect of competence, suggests that experts are both confident and competent in letting others take the lead. This included both colleagues and women.

"She's [defining an expert] got to be a good support person who keeps her head in emergencies, er I think not necessarily stepping in and taking over .if I had an expert midwife who was coming in and helping with emergencies she might sort of support me to be able to help me handle things myself rather than just coming in and taking over or something..." (GI MLU D)

From this, it suggests that the expert midwife does not always take the lead in dealing with emergency situations, thus outwardly displaying her competence and ability. Instead, the expert midwife is able to support colleagues allowing them to take the lead, enabling them to develop their own confidence, competence and skill.

Experts were suggested to demonstrate leadership ability, but they did not necessarily have to be regarded a leader;

"Perhaps they're leaders, perhaps expert midwives', but not all experts need to be leaders I suppose but (hmm) I think you do you need to have this" (GI CLU A)

Leadership qualities identified during group and individual interviews included being innovative, forward thinking, reflective, being a role model, good communication skills, trusting others and being trusted by colleagues. Aspects of leadership will be explored in the subsequent findings chapters.

10.5 Judgment and decision making

The very complexity of decision making, especially in the dynamic process of labour and birth, necessitates shortcuts in reasoning (Cioffi & Markham 1997). Harbison (2000) argues; *'to understand the activity of clinical decision making, one has to draw upon knowledge from such diverse disciplines as cognitive and social psychology, philosophy, artificial intelligence, and statistical theories. In doing so, one has to be willing to range across the 'art' versus 'science' divide: and to value both qualitative and quantitative paradigms'* (p132). Thus, the key to expert performance lies in the individual's memory and perception of situations as a whole rather than in their ability to solve problems quickly or efficiently. Expert clinical judgment is based on the ability to recognise subtle likenesses to previous experiences, and relate them to the current clinical situation (Dreyfus & Dreyfus 1986).

Findings in the current study suggest that aspects of the code 'judgement and decision making' appear to transcend across all codes within the themes wisdom and skilled practice. Experts were argued to be confident, competent, and adaptable when making decisions. This decision making was suggested to be based on a combination of knowledge, experience, and intuition;

'...It's knowing that and not making, because part of you [is] thinking.....well she's only been fully,... well we didn't really know she was fully at all...could have been anything. You just know...you can't measure THAT... you can't measure intuition, which makes you make decisions you do'. (GI MLU C)

Participants in this study argued experts made decisions in situations that were often unpredictable, requiring dynamic and often rapid responses. This is reflected by the following quote;

'Like you have your PPH pathway don't you, that you follow for emergency and just, but, she'll, this particular case she was faced with something that just didn't fit into the pattern. And she had to go sideways to find, other ways to cope with it' (II MLU D)

The quote refers to a clinical scenario presented by the participant. The expert was noted to make rapid decisions when faced with a postpartum haemorrhage in a midwifery led unit. Clinical diagnosis was not simple, as the woman did not present with obvious signs. The expert was observed to make rapid decisions that did not follow the usual protocol. This demonstrated her adaptability, knowledge and skill.

Adaptability was also suggested as an essential skill when dealing with the unpredictability and dynamic process of labour. Participants in this study argued that experts made decisions based on their own clinical judgments, rather than routinely and strictly adhering to policies or guidelines. Although experts were suggested to practice within boundaries of safety and within the sphere of their practice, their practice was not determined or influenced by the fear of litigation. Participants identified the dynamic nature of labour and how the expert was able to navigate and alter her care through the process, delivering care specific to the woman's individual needs;

'and that's really part of the expertise isn't it (hmm), knowing when to control and when to support (yeah) and right through labour it comes and it goes doesn't it?, as the labour changes I suppose' (GI MLU D)

Participants suggested that experts possessed 'an inner knowing' or 'intuitive knowing' of when to provide support and when to intervene. As previously discussed, this ability to be in-tune with women, provide the right balance between control and support, and to make intuitive judgments, requires an inner connectedness within the midwife herself, and also between the woman and the midwife. The expert is able to negotiate the balance between control and support make judgements about whether to stand back, allowing labour to progress naturally, or to take charge and intervene when necessary. This is reflected in the following two quotes;

'..And as long as you recognise, yeah it is slow or yeah it might need you know a bit of a walk about or you might need something to eat, it's doing these things rather than just getting other people involved too soon' (GI CLU A)

'Supposing if something had gone wrong [at a home birth] *she would, if she was suspicious of anything she would just simply just have transferred her in'.* (II CLU B)

In the first quote, participants suggest the expert demonstrates a fundamental trust in dynamic process of birth, giving time to labour and birth. Both quotes suggest that the expert demonstrates the ability to take control of the situation when required. Similar findings were revealed in the prior literature review (Downe et al 2007). We found that experts in the research literature, made judgements during the process of the labour itself, and were observed across a spectrum of *'waiting for the woman'* at one extreme and *'seizing the woman'* at the other (Lundgren & Dahlberg 2002).

Experts in this current study were reported to use interventions as a way of protecting the woman or against further medical intervention. The use of these interventions, which we have termed 'ironic interventions' (Annendale 1998), has been explored in the previous chapter. These interventions were regarded 'the lesser of two evils' and the expert demonstrated the ability to make judgements about whether to intervene or not, or provide additional support, depending on the clinical situation encountered. Thus, providing this balance between control and support appeared to be an essential characteristic of expert practice.

10.6 Summary

This section has explored how the codes 'technical and fundamental midwifery skills', 'confidence', 'competence', and 'judgement and decision making skills' create the theme 'skilled practice'. Experts were skilled in both fundamental midwifery skills and in the use of technical equipment. Experts in this study were argued to demonstrate both confidence and competence, especially when making decisions and dealing with emergency situations. However, this did not always necessitate the expert 'taking the lead'. Experts were suggested to stand back, enabling colleagues to develop their own confidence and skill. They were also suggested to be adaptable, being confident and competent in their ability to make judgements and decisions during the dynamic process of labour. Although experts were suggested to practice within the boundaries of safety and within their sphere of practice, their practice did not appear to be defensive due to the fear of litigation. Decisions were reflexive and reflective, were not dependant upon routine policies or protocols, and were based on a combination of knowledge, prior experiences, and intuition. Thus decision making required courage in situations where actions did not follow the usual protocol.

11.0 Findings chapter 3: Enacted vocation

11.1 Introduction

The word vocation comes from the Latin verb 'vocare' meaning "to call" and may be defined as a summons or strong inclination to a particular course of action (Salvage 2004). As previously discussed, nursing and midwifery has appeared to move away from vocational qualities such as dedication, compassion, kindness and humility, placing emphasis on science and technology instead (Allen 2004). According to White (2002); *'vocations do not require practitioners to act 'above and beyond' occupational norms; they require a commitment to, and identification with, the virtues and values of the occupation' (p283).*

The term 'enacted vocation' was used in the review as it appeared that as practitioners became more expert, they appeared to *'(re)value and to express qualities such as trust, belief and courage, to be more willing to act on intuitive gestalt insights, and to prioritise connected relationships over displays of technical brilliance'* (Downe et al 2007, p136). This theme was first identified in the literature review and encompassed the codes 'values' (belief, trust and courage), 'intuition', and 'connected companionship'. Similar findings were revealed in the current study. However, connected companionship appeared to be more significant than in the review and will therefore be explored in a separate chapter.

This section will be divided into the follow subheadings;
1. Belief and trust in birth
2. Courage
3. Intuition

11.2 Belief and trust in birth

Trust may be argued to be one of the fundamental aspects of midwifery (Calvert 2002). Trust has many interpretations and meanings. Trust may be defined as *'to have belief or confidence in the honesty, goodness, skill or safety of a person, organization or thing'* (Cambridge online dictionary[15]).

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[15] Cambridge online dictionary accessed 20.06.2007 http://dictionary.cambridge.org/

Trust as a component of midwifery care may be described as *'a context from which to provide care, promote normal processes, ensure informed decision making, empower women no matter what choices they make, and, when the woman's choice and midwife's philosophy differ, as a bridge from which to provide effective midwifery care' (Thorstensen 2000).*

Data from the current study suggests that trust is an important aspect of expertise. Participants identified various aspects of trust including trusting in their own judgement, trusting their instinct, forming trusting relationships with women and colleagues, and trusting the normalcy of birth. The first three codes are explored elsewhere in the chapter. This section will focus on trusting the normalcy of birth.

Trust and belief in birth appeared to be a fundamental aspect of expertise. Participants in this current study suggested that expert midwives held a firm belief and trust in the normal processes of birth. They had a fundamental belief in their own skills and abilities, and in the woman's ability to give birth. This is reflected in the following two quotes;

'[the expert] *has beliefs in not only the woman's abilities ... but her own abilities (hmm)'* (GI CLU B)

"...provided the mum and the baby are both fine, and there is a progression, leave them alone. It will happen. It's gone on for a long time hasn't it, without us saying after this many hours that you've had your chance". (GI MLU C)

Gould (2004) argues *'inspiring 'trust' and confidence in the birth process underpins good midwifery care'* (p44). Midwives must have trust and confidence in themselves, and in their own skills, to inspire confidence and trust in women to give birth (Kirkham 2000). However, participants in this study recognised that many women and midwives lack confidence and trust in normal birth. This is reflected in the following two quotes;

'I think that really does open your eyes to [the fact that] *you have to trust what is happening with the woman and I think that is something I have found..... That when people sometimes come from other unit, a busy unit, it does take a while to get*

*out of that consultant mode. Em I'm not saying that everybody, but some people...
even after years.... It's still there.... And I don't think it will go...'* (GI MLU C)

*'It takes a lot of belief nowadays..., women nowadays don't seem to realise, well a
lot of them, that birth is a normal thing. Abnormality is more normal that
normality..., you hear women say I will 'try' don't they now? Rather than they
will. I will 'try' breastfeeding, rather than saying I 'will' breastfeed. I will 'try' to
have a normal birth. They don't seem to think it's something they're likely to have
in the way they talk, which is a shame (hmm)'.* (GI CLU B)

The first quote alludes to the midwives' trust or distrust in normal childbirth and the
effect that previous experiences have on their ability to 'trust' and have confidence in
the normalcy of birth. It is acknowledged here, that even after years of experience,
some midwives do not demonstrate a fundamental trust or belief in birth. This feeling
of distrust can be transferred to the woman, her family, and to midwifery colleagues.
The second quote clearly highlights the participant's perception of women's distrust
in birth and in their own ability to give birth. Participants identified that it was the
role of the expert midwife to instil confidence in women and their partners and to
empower women to trust and believe in their own ability to give birth. This can be
demonstrated through the following three quotes;

*'And getting the woman involved in herself, and promoting the woman's
confidence in, to be able to facilitate the birth, facilitates the labour. Facilitate
birth and keep it, so that the woman feels in control, so that actually the woman is
doing the job. The midwife is just there to facilitate really and to help her'.* (II
CLU B)

*"It's a partnership isn't it between you and the woman and her partner.
Giving her confidence and belief that she can do it herself. Giving her the right
environment (hmm, yeah)".* (GI MLU D)

*'And get them to be more TRUSTING; you know that it will be all right. 'Cause
nine times out of ten it's sheer panic that, that they can go in, and it's that, that in a
lot of people can be transferred to the midwife. You know if the woman starts to get
upset, you start to think is everything not right. You know, and she kind of
overrides that. And has that sort of trust that yes, yeah it's ok, don't worry about it.
You're, you'll be fine'.* (II MLU D)

Experts were also suggested to instil trust and belief in colleagues through the
promotion of natural childbirth practices;

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'Because when we first came over into the new unit... it was very much in it's infancy [water birth]...,. But yes (pause) she (pause) helped and encouraged people to take it up as part of their practice...But just encouraging when anybody came in. 'Have you though about using water?'. And just, and again just being around, just to sort of support.' (II MLU D)

Experts in this study were reported to promote initiatives or practices such as home-birth, and midwifery led care as a way of increasing midwives', and women's, confidence and trust in normal birth;

'And in MLC which one of the midwives runs, erm she wants you to be part of it. So every week, she's getting one midwife from the team to come and see what she does, so that we can help when she's not there... So (names expert) tries to do some night shifts to speak to the night staff as well, and tell them what the MLC room is for, and involve them. It's trying to involve everybody. So that people use it. Otherwise it'll just get dusty like the birthing pool. '. (II CLU A)

However, participants identified that promoting this confidence and trust was often a challenge for experts as midwives were often inexperienced in natural childbirth practices;

'Because not all our community midwives are as comfortable in water. So she was quite happy to come and take over. So she did come and take over and facilitated the birth in the water'. (II CLU B)

'But whereas unfortunately a lot of midwives have never seen a home birth, so promoting it therefore, it could be a problem. Because they have not seen one. Which is difficult'. (II CLU A)

Despite the challenge, experts were suggested to be courageous in their ability to negotiate these challenges. This will be explored in the following section.

11.3 Courage

Clancy (2003) proposes that as one of the four cardinal virtues (prudence, justice, courage, temperance), *'courage acts as a stabilizing factor for the other three'* (p128). Courage appears to be strongly related to leadership (Heischman 2002). However courage is not foolhardiness (Mavroudis 2003). Although practitioners may appear to demonstrate courage when making decisions which involve uncertainty and risk, they

must have knowledge and wisdom, and be aware of risk and consequences of actions taken (Heischman 2002).

Experts in this study were suggested to be courageous in their ability to promote normal childbirth practices, stand up for their own beliefs and those of the woman, and to protect women against unnecessary intervention;

"I am ashamed to say this but a lady did come onto delivery suite, who was contracting 1:2 and the shift leader did say to the midwife who was looking after her "get her ARM'd we need to get her delivered because after three o'clock there's only three midwives' on" [But] she [The expert] said "no she's in normal labour, she'll be delivered way before then, I'm not doing it" (nice one)...but its wonderful that someone feels strong to do that, than perhaps someone who was, more junior might not have has the confidence to do that, it would have been an unnecessary intervention perhaps tipping the woman over the edge' (GI CLU B)

This quote suggests that courage an important aspect of expertise. This finding appears to resonate with the rest of the group, giving strength to the main argument. Experts were reported to be courageous and dynamic in their ability to challenge protocols, cultural norms or unit philosophy, and routine practices;

'I worked with her [expert midwife] in the consultant unit.. not here.. not in this area... and she was just the same there... in a busy consultant unit...delivery suite.. and she was just the same. Protecting normality...' (GI MLU C)

Findings in this study also suggested that experts demonstrated courage in their ability to make decisions based on intuition. This is reflected in the following quote;

'With (names expert) it was her intuition, that took me into hospital really. You know, because I had an urge to push, but I wasn't really pushing, but she said we'll get you in. and I remember saying to her, if I have this baby in the ambulance, I'll be so upset. And she said I'm sorry but you won't. And she just knew. Yeah, which I felt was a, it's nothing that you can write down is it. You know that intuition'. (II CLU A)

Similar findings were also revealed in the literature review (Downe et al 2007). Experts were suggested to demonstrate courage in acting on intuitive insights (Berg & Dahlberg 2001), and were courageous in making judgements that were based on the best interests of the woman and her family (James et al 2003). Aspects of intuition will now be explored further.

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11.4 Intuition

There are various definitions of the term intuition proposed in the published literature (Benner & Tanner 1987; Young 1987; Rew 1990; King & Appleton 1997). It has been described by Truman (2002) as ' *a specific mode of thinking that evolves from the merger of knowledge, skill and experience, and is not always supported by evidence*' (p23).

Benner (2001) argues that intuitive decision making is an important characteristic of expert practice. However, King & Appleton (1997) argue that research suggests that intuition appears to be evident in practitioners ranging from student to expert practitioner and quotes; '*participants pointed out that "gut feelings" are often present in students and newly qualified nurses*' (p199).

In the current study, intuition or 'instinct' was the only theme that did not appear spontaneously in all four units during group interviews. These terms were only evident in transcripts from the midwifery led units. However, further exploration of the meaning attributed to expertise in the subsequent individual interviews revealed that intuition was a significant characteristic of expert practice in all settings.

Midwives in this study described intuition as 'a gut feeling', or a knowing that something is 'not quite right';

'You do, you do sometimes just get a feeling that something isn't right, you can't see any reason or anything, but you just get that feeling in the pit of your stomach that something is not right... ...You just don't know where it comes from, I really don't know where it comes from but you do, you do feel it' (GI MLU D)

'it's intuition isn't it. Knowing that something's not right' (II CLU A)

It was argued that intuition was something that cannot be quantified or measured;

'You just know.. you can't measure that... you can't measure intuition, which makes you make decisions you do' (GI MLU C)

Intuition was suggested to be a skill that most people possess;

'You know things like intuition. You can't learn it as such...Everybody has intuition anyway in life don't they. So hopefully you can take it to your practice'. (II CLU A)

However, it was argued that midwives must experience a range of situations focussed on the normal or natural processes of labour in order for midwives' specific intuition to develop;

'But if you haven't had the time or the skills to see intuition, say like [if you've only seen] *a woman with an epidural, and monitoring all the time, then how could you use your intuition to see if there is a problem'* (II CLU A)

Therefore, in order for intuition and thus expertise to develop, midwives must encounter and experience the physiological or natural processes of labour, so that they are able to recognise the normal process of labour, and when deviations from the normal occur. Thus, experts appear to sense the situation using their hands, eyes and ears, rather than relying on monitors or machines;

'its there as a good back up [technology or equipment]. *It's not the thing you go to first. It's there as an addition. You know it's not,.. primarily it's your (pause) your hands and your eyes that she* [the expert] *would use. You know, get a feeling of the woman first, and then use it as a back up'* (II MLU D)

Although midwives were unable to justify where intuitive knowledge came from, they suggested that intuition was facilitated through prior experiences, and through the midwife-woman relationship. As in an earlier study conducted by Davis-Floyd (1996), participants in this study recognised the importance of intuition, but were apprehensive about their capacity to justify decisions made on this basis;

'It's having the background knowledge as well, because your gut feeling is whatever, but you have to be able to back that up because you know you couldn't stand up and defend yourself "oh well I just thought that". Your gut feelings don't matter in court' (GI MLU D)

Davis (1995) suggests this lack of trust was fundamentally due to *'a society that values 'hard data' and results of technology,* therefore *many people possess an inherent lack of confidence in intuitive knowledge' (p30).*

Intuition requires an inner connectedness within the midwife herself, and also between the woman and the midwife. This was also evident in Davis-Floyd's (1996) study where she quotes; *'intuition... emerges out of their own inner connectedness to the deepest bodily and spiritual aspects of their being, as well as out of their physical and psychic connections to the mother and child (p260).* Baylor (1997) argues that this connectedness is an intrinsic property of intuition, and essential to the development of expertise. This connected relationship will be explored in the following chapter.

11.5 Summary

This chapter has explored the concept of enacted vocation. Data from the current study suggests that experts appear to use and value technical, fundamental and vocational skills in order to integrate the art and science of midwifery and provide effective midwifery care. Experts are highly intuitive, and possess a strong belief in their own skill and ability. Experts appear to hold a strong fundamental trust and belief in birth, and demonstrate courage when challenging cultural norms and routine intervention. They are skilled in their ability to use their senses to detect deviations from normal, and to facilitate a connected relationship with labouring women. This connected relationship will now be explored in the following chapter.

12.0 Findings chapter 4: Connected companionship

12.1 Introduction

The relationships formed between the expert midwife and her colleagues, those relationships formed with women for whom she cares, and the consequent creation of an environment of mutual trust, have formed the concept 'connected companionship'. Connection refers to physical, emotional, intellectual, and psychic relationships (Davis-Floyd 1996). The holistic midwifery philosophy is suggested to value inter and intrapersonal connection and the connected relationship may be described as a connected dance (Davis-Floyd 1996).

Baylor (1997) suggests that the *'formulation of connection is based upon a person's knowledge structures which reflect his/her level of expertise'* (p188). We have chosen the term 'companionship' as it necessitates a relationship which is founded on mutual respect and trust. The term 'connected companionship' was first identified in the literature review (Downe et al 2007) and denotes a relationship that is characterised by profound caring and deep understanding. However, in the original review, the code 'connected companionship' related to the relationship between the expert and the woman. In the current study, this theme appeared to be more significant than in the original review, denoting relationships between the expert and the woman, expert and her colleagues, and the relationship between the woman, the expert and the birth environment.

The following codes represent the theme 'connected companionship' and will form the structure of this section;

1. Midwife –Woman relationship
2. Midwife-Colleague relationship
3. Creating an environment of trust

12.2 Midwife-Woman relationship.

Flemming (1998) suggests *'the practice of midwifery itself represents a coming together of midwife and woman' (p139)*, with each relationship formed being unique.

Despite the significance placed on the value of the midwife-woman relationship, there appears to be little authoritative research or scholarship in this area. Indeed, as Mavis Kirkham comments at the beginning of her book 'Midwife mother relationship' *'If midwifery is conducted in and through the relationship between the woman and the midwife, it is strange that this is the first book on that relationship'* (Kirkham 2000 pxiii). In contemporary midwifery practice, *'midwives are expected to work in partnership with women, meet women's emotional needs and facilitate women's informed choice'*. (Hunter 2006, p320)

Participants in this current study recognised the importance of the midwife woman relationship, and suggest the relationship is built on trust and equality, and facilitated through continuity of carer. The terms 'partnership' and 'friendship' were commonly used to describe the relationship;

'it's a partnership isn't it, between you and the woman and her partner' (GI MLU D)

''to be with the woman, you know, just as a friend' (GI MLU D)

These terms have also been cited in the literature (Walsh 1999; Pairman 2000). The term 'friendship', is used to describe a relationship based on *'reciprocal love and intimacy, trust, warmth and genuine concern' (Pairman 2000, p224)*. A friendship is usually a relationship which is voluntarily entered into, whereas the purpose of the midwife woman relationship is to give and receive good midwifery care (Pairman 2000). Therefore, the suitability of this term in its use to depict the midwife-woman relationship may be questioned. On the other hand, the term partnership may be described as *'working together towards a common aim'* (Freeman et al 2004, p8). In a partnership both participants ideally have equal status, sharing power and control (Pairman 2000).

There are times when the midwife-woman partnership may be unequal. This may occur when the midwives' personal and professional project of birth and women's choices cause conflict, or when the woman makes decisions which the midwife regards as detrimental to her health, or to that of the fetus. This may challenge the balance of the midwife woman relationship. Findings in this current study suggest

that the expert is able to negotiate this conflict through facilitating a trusting birth environment, valuing and supporting women's choices, and through establishing trusting relationships with women, their family, and colleagues. This is reflected in the following two quotes;

'you need to have discussions that are honest, and at the end of the day.. if they choose, whatever way they choose, and you have given them a real.. honest... true.. informed choice.... Then you support them. And you trust in your colleagues... to go along... to be able to support you. And them as well'. (GI MLU C)

'It's giving them information and allowing them to make an informed choice as oppose, and trying to support them in their wishes and not forcing your wishes upon them which I think is very easy as a midwife'. (GI CLU A)

It appears that midwives in general place importance on the values 'truth' and 'honesty', and by giving true and honest information, they facilitate informed choices. This relationship is facilitated through effective communication. Both verbal and non-verbal communication was suggested by participants to be essential to the development of the midwife-woman-relationship. This is reflected in the following quote;

'I think eye-to-eye contact is huge. Whoever, you and the partner, the woman,... I think it builds trust'. (GI MLU C)

Supportive techniques were also suggested to facilitate the relationship;

'Encourage her, encourage the labour. Encourage the woman. Hands on, for comfort, and using all sorts of, well I suppose you can call them techniques'. (II CLU B)

These supportive techniques may be physical or emotional and include high touch, hands-on midwifery practices, or providing warmth, nurturing, gentleness, kindness, caring, and positive encouragement (Kennedy 2000; Sleutel 2000; Berg & Dahlberg 2001; Lundgren & Dahlberg 2002; James et al. 2003).

Participants in this current study suggested that experts were valued for their positive characteristics that facilitated emotional support;

'At the end of the day you want somebody who's looking after you and nurturing you and that, don't you, when you're having a baby". (GI MLU D)

Thus, it appears that the expert does not, in fact, have to support the woman physically. It may be that the presence that the expert portrays denotes expertise. The terms presence or presencing refers to ways of "being there" or "being with" another (Nelms 1996; Benner 2001). Presencing is a process that is characterised by sensitivity, intimacy, holism, and an adaptation to unique circumstances (Finfield-Connett 2006). Participants in this study recognised the importance of being-with women. They acknowledged the importance of being 'present' or 'being there', but not necessarily having to do anything physical;

'And she did nothing, she just sat there. ...because sometimes it does look like they're not doing much. But you hear that the best midwives' are the ones that sit on their hands, and do nothing'. (II CLU A)

'I like water birth, you can't do anything. You sit back (laugh), you're chatting aren't you. You're talking. You're not touching them..' (GI MLU C)

The term 'presence' relates to the midwives' ability to guide and encourage, creating an unobtrusive environment of safety and calm (Anderson 2000). Heidegger (1962) defines 'presencing' as a special way of 'being there' or 'being with' another. In her exploration of nursing expertise, Benner (2001) identifies presencing as an important aspect of the helping role, and therefore an important aspect of nursing expertise. In her studies, Kennedy defined the term as being present for the woman but not actually doing anything physical (Kennedy 2002; Kennedy et al 2004). Kennedy used the term 'engaged presence' to describe the essence of the relationship or 'connection' the expert midwife has with the woman. The following quote from this current study captures the essence of 'engaged presence' or 'connected presence'

"I sat back and watched her do what her body told her to do, and she got into whatever position she felt like and laboured very normally, very quickly, very nicely, very normal delivery and I did nothing only er occasional listening to fetal heart that was all I did and it was, it was nice that it went well. It was quite an eye opener for me, to do nothing .....but encourage and support". (GI CLU B)

However in order to be connected *'the midwife must first know and understand the woman, and work with her as partner in the birth process'* (Downe et al 2007, p136). As previously suggested, this connection is suggested to be facilitated through continuity of care, through giving true and honest information, supporting women's choices, and facilitating a calm and trusting birth environment. These issues will be explored in the final section of this chapter.

12.3 Midwife-colleague relationship

The relationships that expert midwives form with colleagues is an area that has not been widely explored in the research literature. However, a study conducted by Hunter (2005), argued relationships with midwifery colleagues were of key importance to hospital midwives, providing the main source of feedback on individual practice. Both verbal and non-verbal communication was reported to be an important aspect of the midwife-colleague relationship.

Participants identified that in order to facilitate positive working relationships, the expert midwife would strive to create an environment of trust. As previously discussed, trust is essential for the development of the midwife-colleague relationship. This environment of trust was facilitated through teamwork, collaborative relationships, through a relaxed atmosphere and approach, and through advocacy and support;

'I think it's important that we (we work as a team) we do work as a team, (yeah)'
(GI CLU A)

This team work was suggested to be significant and occurred between midwives and midwife colleagues, doctors, managers and the women themselves. It denotes a relationship built on mutual respect and trust, and facilitates a supportive birth environment. This is reflected by the following two quotes;

'we've got a midwife who has worked here 20 odd years, their opinion, they are valued aren't they? Their expertise. (yeah)' (GI CLU A)

"Well that's where supporting each other comes...And to have an atmosphere that you can ask people". (GI MLU D)

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Participants in this study described a 'connectedness' that occurred between midwives;

'You know as you stood there to deliver, you look at your colleague.... You know what's going to happen next... you don't have to say anything... the eyes say it all' (GI MLU C)

In order for this connected relationship to flourish, midwives expressed the need for relationships to be based on trust, equality and collaboration. A sense of knowing and trusting colleagues, working together as part of a team, and working towards the same goal were expressed as important concepts in creating an effective working environment.

"..Have trust in the people that we work with, we do work together and ask one another questions, and reflect on things as midwives' together...That is important to the working relationship with your colleagues..." (GI MLU C)

Experts were suggested to 'nurture newly qualified staff', providing encouragement and support. Experts created a supported environment conducive to learning, where colleagues felt comfortable to ask questions. Thus experts were able and willing to share their knowledge, experiences and expertise;

"...to work in a unit like this..... Or even out in community, because you are thinking very much for yourself, and you have got to rely on yourself and your colleagues..." (GI MLU C)

Experts were also suggested to value the experiences, knowledge and skills of others. They were willing to learn, and identified limitations in their own practice:

'you do get to a point sometimes where you, you know if it has been slow progress that you do need a (fresh) you do need fresh eyes (yeah) and that can be good.' (GI MLU D)

Their expertise did not always have to be 'on show', as they were confident in their own ability to stand back and let others take the lead. The following two quotes represent this theme;

"She's [defining and expert] *got to be a good support person who keeps her head in emergencies, I think not necessarily stepping in and taking over ... she might sort of support me to be able to help me handle things myself rather than just coming in and taking over or something..."* (GI MLU D)

"I think you've got to step back and let people learn as well (hmm). You know, not, not interfere but erm to let them learn in their own way' (GI MLU D)

Thus, experts created an environment of trust which is conductive to learning and facilitates a trusting environment. This aspect will now be explored.

12.4 Creating an environment of trust

Anderson (2000) suggests *'a skilled and sensitive midwife can create an unobtrusive atmosphere of safety and calm, which allows women to feel secure enough to just disconnect mind from body....... An intrusive midwife can just as easily block a woman's being able to do this, undermine her confidence in her own body and turn her experience of giving birth into a nightmare'* (p117).

A supportive environment and strong support network is suggested to be fundamental to an effective working environment (Butterworth & Bishop 1995). Schaub & Altimier (2006) argue *'trust has a beneficial impact on many aspects of working life, including job satisfaction and organisation effectiveness, and both these factors have been shown to affect the quality of patient care.'*(p19). There is literature supporting the benefits of providing the right birthing facilities, and providing the right support in order to improve maternal physiological and physical wellbeing (Page 2006).

Participants suggest that a supportive environment is built on a foundation of mutual trust between health professionals themselves and between midwives and labouring women. Experts demonstrated the ability to facilitate a relaxed atmosphere, and thus create an environment of cooperation and trust where colleagues were able to ask questions and learn from each other. This environment of trust is suggested to be of benefit to both women and midwives as it allows expertise to develop, and facilitates a cycle of empowerment.

However, as previously discussed, participants acknowledged that time constraints and other environmental factors such as poor staffing can have a negative effect on

these relationships, and thus on the birth environment. Unique philosophies, characteristics, skills and attitudes of the midwife may also play a significant role in shaping the birth environment. Participants suggested that differing philosophies caused disharmony in the working environment, and may influence birth outcomes:

"It's not a skill mix skill mix that way (no) is it (its attitude mix). Attitude mix (laughs). You might think yeah maybe, put them two on together ....does a midwife one particular midwife or two particular midwives seem to have more transfers than others' (GI MLU D)

Those who have a fundamental distrust in birth can transfer this distrust to colleagues and to women themselves. In contrast, those midwives who fundamentally trust the normalcy of birth, and trust women's ability to give birth, strive to provide a specific kind of space in which women can birth their babies

'So if there's any way of kind of keeping it safe and giving the woman what she wants then that was at the essence I think'. (II MLU D)

Attention was paid to the ability to facilitate normal birth and a positive birth experience regardless of clinical setting;

'facilitating her birthing her own baby in whatever setting she's working. Whether it be in a high risk area, to keep as normal as possible, or whether it be perfectly low risk woman delivering at home'. **(II CLU B)**

And also to the aesthetics of the birth environment itself;

'The home from home room has an erm, instead of bed, it's like a bed settee, which it can go into a bed if needs be. And then there is a birthing ball, a shower in the room, and a toilet as well just through a door. And it has all nice pictures and nice cots with all coordinated bedding and stuff like that. Which is like home from home. Whereas the delivery suite has the BIG light, and the bed in the middle of the room. Resuscitation equipment on show, but we do have a curtain that you can pull round, but It's still there. And it's very medicalised erm. There are no pictures on the wall. The pictures on the wall are for the midwives', of emergency situations like what to do if there is a shoulder dystocia or you know things like that. Erm, which, where we've got pictures in the MLC room, of mothers and babies, and you know, nicer things. Like twigs that have got lights on'. (II CLU A)

Similar findings were found in a study conducted by Kennedy and colleagues (2004) where the expert was suggested to 'orchestrate labour', thus creating a safe space for

the woman to give birth. This safe environment appears to be underpinned by the expert's fundamental trust in birth, trust in the woman's ability to give birth, and support of women's choices. Participants in this study identified that one characteristic of expert practice was the ability to negotiate these challenges to facilitate a positive birth environment.

12.5 Summary

This chapter has explored aspects of the connected relationship that the expert midwife establishes with women and their colleagues and how they facilitate the right environment in which these relationships can flourish. Experts were suggested to create an environment of trust through collaborative relationships with colleagues. Trust appeared to be a fundamental component of the relationship. Being present in the room, allowed experts to develop connected relationships with women.

The following chapter will synthesise the five findings chapters and explore a model of intrapartum midwifery expertise.

13.0 Discussion and synthesis

The characteristics and skills required for expert intrapartum midwifery practice have been explored in the previous chapters. The four themes identified can be synthesised into three domains of expert midwifery practice; 'physiological expertise', 'technical expertise' and 'integrated expertise'
(see Figure 1).

13.1 Figure 1. Domains of midwifery expertise
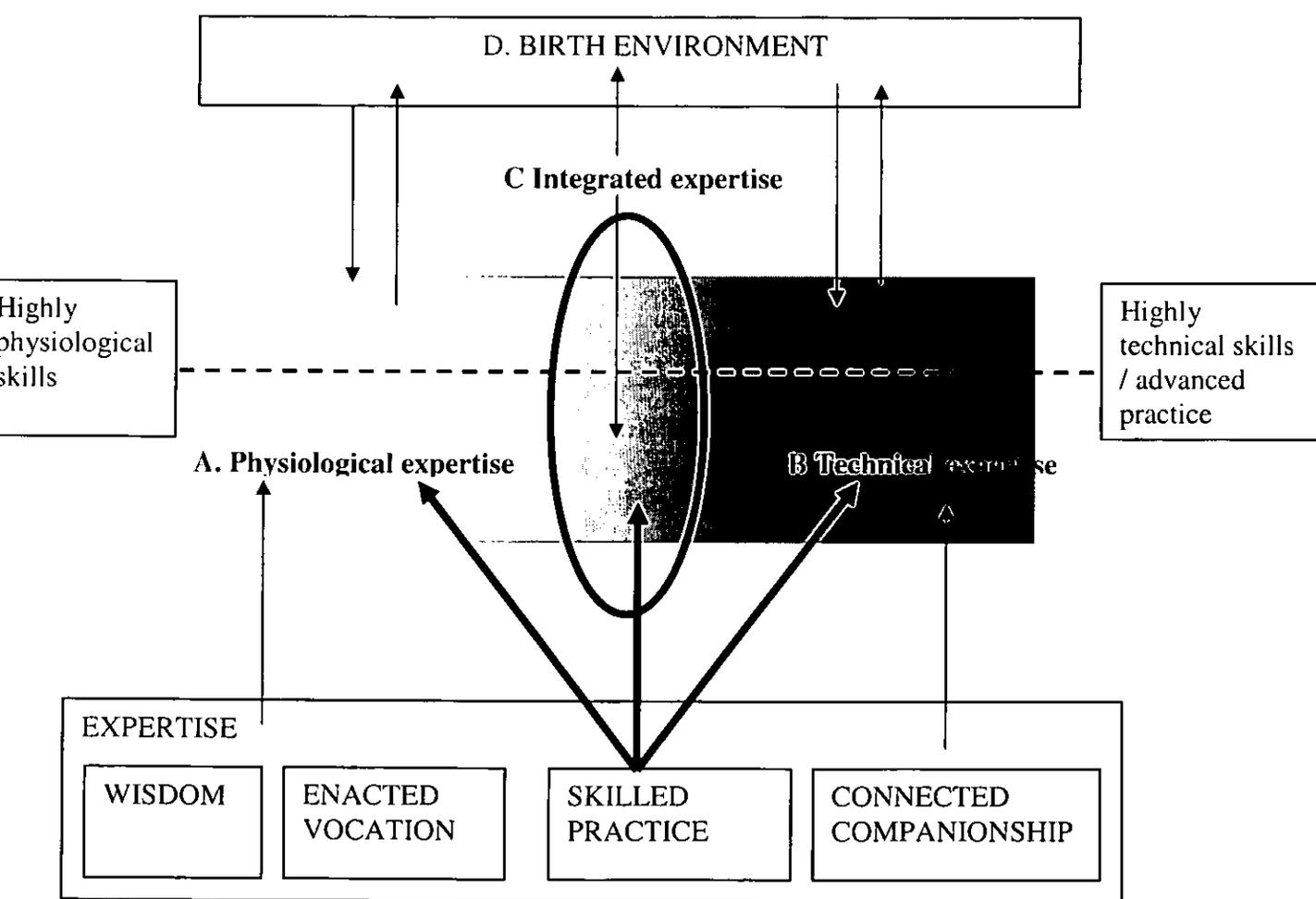
(A) Expert who demonstrates expertise in normal childbirth only.

(B) Expert who demonstrates technical brilliance and highly skilled in using equipment and birth technology.

(C) Integrated expert. This expert strives to promote normal birth, but is competent in using birth technology. Able to demonstrate expertise in high risk and low risk settings, and practises the same regardless of clinical environment.

(D) Birth environment. Influenced by all three domains of expertise. In turn, the environment affects the capacity of midwives with technical and physiological expertise, but not integrated expertise.

As represented by figure 1, the four key themes 'wisdom', 'skilled practice', 'enacted vocation', and 'connected companionship' are fundamental to expertise. It appears to be the level of skilled practice that determines the specific domain of expertise. At one end of the spectrum, there appear to be 'experts in high-risk childbirth'. These experts have been defined as 'technical experts', characterised by their ability to display technical brilliance, being highly skilled in using equipment and birth technology. The extreme pole of technical expertise has been defined as 'advanced practice or highly technical'. These skills include more specialised practice such as performing ventouse deliveries. At the other end of the spectrum, there appear to be 'experts in normal childbirth'. These experts have been defined as 'physiological experts', mainly working at home or in birth centres. In this study, 'integrated experts' were most commonly described by participants, being characterised by the ability to demonstrate expertise in high-risk and low-risk settings, transcending their expert skills through boundaries of normality and pathology.

Separate, but also alongside the domains of expertise is the clinical environment. Both the 'technical expert' and 'physiological expert' appear to influence and are influenced by the birth environment. In other words, those who are regarded technical experts only demonstrate specific areas of expertise evident in a technical setting. Physiological experts only demonstrate expertise in a low risk setting. In contrast, the practice of 'integrated' experts does not appear to be influenced or affected by the birth environment. These issues will be explored in this chapter under the following sections:

2. General concepts of expertise
3. Integrated expertise
4. Technical expertise
5. Physiological expertise

13.2 General concepts of expertise

In the previous chapter four themes were identified (Wisdom, skilled practice, enacted vocation, and connected companionship) which determined expert practice. Participants suggested that fundamental skills that essentially made or defined these midwives as experts, were the same regardless of whether they worked in high-risk or low-risk settings. This can be demonstrated through the following two quotes;

"If you are an expert it really doesn't matter what your field is. ......But I would say (mentions a midwife's name) is a expert in normality (yeah) (yeah)...she's as passionate and as committed to normal midwifery as the core, the shift coordinators are passionate about monitoring and into high-tech midwifery so to me there isn't a difference but that's just me." (GI CLU A)

"You're still adaptable, you still need to be able to communicate, erm you still need to be able to know when to ask for help, whichever area you work in (yeah). The basic qualities are the same (hmm), but your interests are different I suppose (hmm)...........But I think you're all working towards the same goal at the end of the day aren't you". (GI MLU D)

However, participants in this study identified that midwives could not demonstrate expertise in all areas of practice;

'You don't have to be an expert in everything. You could have something that you have got expert knowledge and expertise in, and something that you've not'. (GI MLU C)

Benner and Tanner (1987) in their exploration of intuition and expertise suggest that experts can only function as experts in their own specialist areas.

This was also evident in the current study as experts were suggested to demonstrate specific areas of expertise. Findings from this study suggest that these specific areas of expertise can be observed across the spectrum of normality and pathology. Those experts who possessed skills that transcended both areas were defined as 'integrated experts'.

13.3 Integrated experts

This domain of expertise appeared to be the strongest of the three. For the purpose of this discussion, the integrated expert may be characterised or defined as;

'The integrated expert possesses the essential personal characteristics, and demonstrates the necessary skill and ability to promote normal childbirth, to recognise deviations from the norm and to use technological interventions appropriately in order to facilitate optimal birth outcomes for childbearing women, and to fulfil the emotional, physical and spiritual needs of the woman and her family in any setting. Integrated experts respond dynamically to a range of settings, positively influencing the setting and those working within it'.

This section will be separated into the following sub-headings;

a) Expertise in high-risk and low-risk practices

b) Working with the technology or environment to maximise normality

c) Leading the fight for normality

d) Working within the professional project of birth

13.3a Expertise in high-risk and low-risk practices

Integrated experts demonstrated expertise in both high-risk and low-risk childbirth practices:

'She'll know when to get the doctor. And in emergency situations, she's absolutely brilliant. She knows exactly what to do)" (II CLU A)

Experts were suggested to be knowledgeable and competent in dealing with high risk situations, and were reported competent in using birth technology. However, 'integrated' expertise was argued to be something more than simply possessing technical skills;

'Erm, it's there as a good back up [technology]. *It's not the thing you go to first. It's there as an addition. You know it's not, primarily it's your (pause) your hands and your eyes that she* [the expert] *would use. You know get a feeling of the woman first, and then use it as a back up'* (II MLU D)

Thus, integrated experts did not rely on technology. Instead, equipment or technology was regarded by experts as supplementary to the fundamental midwifery skills.

13.3b Working with the technology or environment to maximise normality;

Integrated experts appeared to be passionate about normal or physiological birth. The ability to promote or strive for normality in a variety of settings was reported the fundamental skill that defined 'integrated' expert practice;

'So my expert would be somebody who can look after a normal labouring woman and facilitate her care, and facilitating her birthing her own baby in whatever setting, she's working. Whether it be in a high risk area, to keep as normal as possible, or whether it be perfectly low risk woman delivering at home. So that would be my definition of an expert midwife'. (II CLU B)

Integrated experts were suggested to be motivated in their ability to promote and practice physiological birth, they practiced a women centered philosophy, demonstrated passion and commitment to midwifery, and were dynamic and innovative in practice. This is reflected in the following two quotes;

'The particular one [expert] I'm thinking of is dynamic, very interested in improving what we've got'. (II MLU D)

'And she's, she's erm very progressive, she's always like forward thinking isn't she's she like erm (motivated) , she's, she's involved in introducing the teams wasn't she, she was involved in the midwifery, trying to set up the midwifery led'. (GI CLU A)

They appeared to work with the technology in the birth environment and not against it, in order to maximize normal childbirth:

'But you see expert midwives, keeping women, even if women are quite high risk, not erm, going past the safety aspect, but if they need to go on a monitor, keep them on the monitor, but perhaps if they can sit on a ball, or even go on their hands and knees on the bed'. (II CLU A)

'One of the midwives (names expert) she's really good. If say, you are struggling and it's been over two hours of pushing whatever, she can come in and she'll try with her fingers to rotate the head to bring the head down. She's worked there thirty odd years, you know her skill is just, she's very calm, again, calm. And but then she knows if it's not going to come out. She'll know when to get the doctor.....No she's also an expert in normality. Because she's saved if you like, a lot of women from having a caesarean' (II CLU A)

Both quotes refer to strategies or interventions used to maximise normal birth. The second quote refers to what we have termed 'ironic interventions' in the previous chapter. Thus, the expert carries out the procedure or intervention as a way of protecting the woman from further intervention (instrumental delivery or caesarean section), and in order to promote normality.

This current study suggests that the integrated expert has similar attributes and skills to the 'humanistic existentialist expert' as described by Conway (1996). In a later paper, Conway (1998) further defines the characteristics of a humanistic existentialist expert;

'Humanistic existentialists were very dynamic and had a strong nursing focus of care. Patients were truly viewed holistically and a humanistic philosophy was used in practice. These experts were passionate about nursing practice.....they exerted considerable power and influence and saw themselves as creating the culture in their areas.... Self awareness and reflective abilities typified this group...' (p79)

The terms dynamic, strong-focus, holistic, considerable power and creating the culture, appear to be powerful words resonating with aspects of leadership. This aspect will now be explored.

13.3c Leading the fight for normality

Integrated experts appeared to challenge practices that would undermine normality, and were courageous and innovative in their ability to facilitate normal birth. They were referred to during interviews as innovative, champions or leaders, striving for normality;

'But going back to (Names expert on labour ward) again, she erm, she's like an inspiration really. Because she does things above and beyond what she needs to do. Especially with like setting up Midwifery led care. If it wasn't for her, then it wouldn't have been set up at all. And she's done really well to do that' (II CLU A)

[How does the expert facilitate normality?] 'Well I suppose, initially it would be water [birth]. ...she helped and encouraged people to take it up as part of their practice....But just encouraging when anybody came in. Because she felt it was safe. And she didn't have the experience either. Of doing it. But just to see how it would go, and to make sure that it was safe, she'd be around and support people doing it' (II MLU D)

The above two quotes suggest that the expert is innovative, dynamic, and courageous in their ability to implement changes in order to promote normal birth. Schaub and Altimier (2006) suggest that leaders are clear about their values and beliefs and act consistently with them. They argue *'leaders have a 'vision' and are guided by integrity and ethical decision making whilst working towards that vision'* (p20). Integrated experts therefore appeared to demonstrate a strong fundamental trust and belief in normal birth. This strive for normality appeared to be the experts 'vision' for midwifery practice.

As previously explored, experts were suggested to be innovative in practice, and implement practices such as midwifery led care schemes, or promote practices such as water birth in order to maximize normality. Experts were suggested to create a climate of trust through promoting both women's and midwives' understanding and trust in birth. They demonstrated the ability to facilitate a relaxed atmosphere, and thus create an environment of cooperation and trust. Experts demonstrated the courage to remain 'with woman' protecting them against unnecessary intervention, and demonstrated the ability to promote or strive for physiological birth. This is demonstrated through the following two quotes;

[Defining essential skills for the expert in physiological birth]" ... *standing up.... Fighting for normal birth. Because you have to... especially here. ... You need to fight".* (GI MLU C)

[Describing an expert midwife in physiological birth] *"Always wanting to book home births and ..... Kept campaigning (yeah, yeah, tenacity I think is the word), (hmm). But very, very knowledgeable as well (very). (and dynamic)"* (GI CLU A)

Both the terms 'fight' and 'campaign' suggest that experts are required to put a lot of effort in, or struggle in order to achieve or promote normal birth. Thus, experts appeared to demonstrate courage in their ability to challenge practice and facilitate normality.

13.3d Working within the professional project of birth

Participants identified the dynamic nature of labour and how the integrated expert was able to navigate and alter her care through the process. In her study, Kennedy (2004) suggests the expert is able to orchestrate care, *'creating an environment in which the woman's desires were met...... and where normalcy was preserved' (p18).*

Thus she possessed the exceptional ability of knowing when to support and when to intervene. This 'knowing' was suggested to be based on a combination of knowledge, experience and fundamentally based on intuition. Integrated experts were reported to be highly intuitive, and through their connection with women (and through their own inner connectedness), they were able to facilitate optimal birthing through the promotion of individualized care;

'and that's really part of the expertise isn't it (hmm), knowing when to control and when to support (yeah) and right through labour it comes and it goes doesn't it?, as the labour changes I suppose' (GI MLU D)

Integrated experts were suggested to support women's choices, even if their values and beliefs differed from their own beliefs;

"It's giving them information and allowing them to make an informed choice as oppose, and trying to support them in their wishes and not forcing your wishes upon them which I think is very easy as a midwife". (GI CLU B)

'If the woman wants to be induced or if she wants an elective section. Then it is up to that woman. So long as they know all the for and against everything. It's all right going on about normalising everything, but what if that woman doesn't want it. It's difficult isn't it? Because we can, well from personal point of view, you can think that it's better having a normal birth. But some women don't think that'. (II CLU A)

Therefore, integrated experts demonstrated an ability to provide a balance between the personal and professional project of birth and women's choice. Care is therefore holistic, individual and client led.

13.4 Technical experts

Technical expertise appeared to be a concept that was superficially explored by participants, and would require further exploration in future studies. Participants in this study alluded to a type of expertise which was specific to high-risk childbirth. Technical experts demonstrated technical brilliance and were skilled in using equipment and birth technology. It is evident in practice and in the literature that the role, skills and boundaries of midwifery practice have become expanded, extended and developed (Daly & Carnwell 2003). Midwives are now adopting roles such as ventouse practitioners, midwife ultrasonographers, drug liaison midwife and undertaking extended skills such as IV cannulation, which were previously conducted by medical practitioners (Lavender 2007). Terms such as advanced practice, higher level practice or specialist practice have been used to describe the expansion of the midwifes' role. Advanced midwifery practice may be defined as adjusting the boundaries for the development of future practice. Specialist practice appears to be more specific, demonstrating higher levels of knowledge and judgement in a specific

area of practice (Durgahee 2003). The term specialist may be defined as *'someone who has a lot of experience, knowledge or skill in a particular subject'* and technologist as *'someone who works with a particular technology'* (Cambridge online dictionary[16]). Thus, experts in high risk care are specialist in their knowledge and skill attributed to high risk intrapartum care, and in using birth technology.

Technical experts were suggested to influence the birth environment, and be influenced by the birth environment. It may be argued that technical experts would not demonstrate expertise if they were taken out of the high-risk setting.

13.5 Physiological experts

This domain of expertise was alluded to by participants; however it was not explored in-depth. Experts in low risk or normal childbirth appear to be characterised by their ability to promote normal childbirth practices in specific low risk settings such as at home or in birthing centres;

'... being a community midwife, I haven't actually worked with her on delivery suite at all. She's perfectly competent and able to use the equipment and would be able to follow protocols and so forth and so on. And she keeps herself up to date. But she would prefer the normality of community really...That's sort of where she shines. Out in the community' (II CLU B)

Although experts in low risk childbirth were suggested to be competent in using equipment and following protocols within a hospital setting, they demonstrated expertise predominantly in a low risk setting. The community setting was suggested to be an area of practice for physiological experts.

Thus, it may be assumed that physiological experts are more confident and comfortable working in low risk environments, and consequently if they were to be moved to a high risk setting, this would affect their confidence and expertise. This integration from community to hospital ways of working often requires practitioners to be able to navigate the different philosophies and practices of care and has been cited by authors as a source of emotional stress for midwives (MacFarlane & Downe

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[16] Cambridge online dictionary accessed 20.06.2007 http://dictionary.cambridge.org/

1999; Shallow 2001; Hunter 2004; Hunter 2005; Hunter 2006)   Although not spontaneously suggested by participants, it may be argued that the practice, confidence and competence of physiological experts is influenced by the birth environment, which essentially differentiates them from the 'integrated' expert. This fits with the perspective of Benner and Tanner (1987) who argue that experts can only function as experts in their own specialist areas. However, this would require further testing in future studies.

13.6 Limitations

There are two main limitations to this study. The first relates to the initial focus of the research being on aspects of normal childbirth and expertise specific to this area; the second relates to the sample. Each of these issues will be explored separately.

Focus on normality

The initial focus on normality and expertise in this area was reflected in our group interview guide which addressed domains of expertise; with expertise in normal childbirth being given specific focus. Thus, some of the initial data may have been prompted by this. The process of the research study and writing of the thesis tested this focus. The focus then became more about expertise per se, with expertise in normal childbirth being one characteristic on a spectrum of expertise.

Data from the follow up interviews identified a spectrum of intrapartum expertise ranging from physiological experts to technical experts, with integrated experts demonstrating skills that transcended normality and pathology. However, the ability to promote physiological birth in any clinical setting was deemed essential to integrated expert practice. Thus, it appears that despite the initial focus on normality in the group interviews, when allowed to explore the nature of expertise in the follow up interviews, participants re-focussed on aspects of expertise in normal childbirth. However it is difficult to ascertain to what extent the group interview process had an effect on the data obtained during subsequent individual interviews. It must be acknowledged that although there was a period of twelve to eighteen months between some interviews, participants were given a summary of the analysis of group interview data prior to the individual interviews. This may therefore have influenced the data in the follow up interviews.

Further individual interviews may have illuminated different aspects of intrapartum expertise specifically relating to technical expertise and physiological expertise. However, due to limitations of time, funding and resources, it was impossible to conduct additional interviews. This may be considered another limitation of the study.

Study population

In order to capture a wide range of midwives' views, we included midwives working in various clinical settings including midwifery led units and consultant obstetric units in the North West of England. The rationale for this was based on our prior beliefs that midwives working in different environments may have different philosophies underpinning their practice, and would experience different influences on their practice. In other words, the initial thought was that midwives working in low risk midwifery led units would demonstrate a fundamental belief and trust in birth and would be confident and competent in normal birth practice. It was anticipated that midwives working in a consultant unit with a high rate of normal birth would demonstrate expertise in promoting normality within a hospital setting, and midwives working in a consultant unit with low rates of normal birth would reflect the perceptions of midwives working in a technological environment. These preconceptions were unfounded and not reflected in the research findings, as midwives with different philosophies were evident in all clinical environments.

It is acknowledged that qualitative research is subjective and that it does not claim to produce results that are representative to the general population (Sim 1998). However, our limitation to the North West of England and inclusion of only one pre-registration (direct entry) midwife may have affected the transferability of the findings. The significance of this is unknown. However, further exploration into the views of pre-registration or direct entry midwives' to capture the views of such midwives, would illuminate any differences in findings.

The limitation to the North West of England was due to funding and resources. Inclusion of a diverse range of both high risk units (for example units which promote the use of midwife ventouse practitioners) and low risk units (birthing centres), may have uncovered further data relating to specific domains of technical or physiological

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expertise.

Despite the limitations identified, the findings from this study appear to reflect and extend those identified in the earlier review (Downe et al 2007). This suggests that the concepts of wisdom, skilled practice, enacted vocation and connected companionship appear to resonate with expertise in countries including USA and Sweden. However, it must be acknowledged that these countries reflect a specific culture of westernised maternity care. It may be argued that different aspects or domains of intrapartum expertise may be important to countries where high mortality rates are evident. Further research would therefore be required to test this theory.

13.7 Summary

Findings of this study suggest there are three domains of expert midwifery practice in Western settings. Integrated expertise appears to be the strongest of the three, being characterised by the expert's ability to work across boundaries of normality and through differing models of care in order to promote optimal birth outcomes for women, keeping a focus on the normalcy of birth. The integrated midwife expert possesses essential personal characteristics, and demonstrates vocational qualities such as patience, caring, and the ability to nurture. However, they are highly skilled in their ability to recognise deviations from normal, rapidly responding to the reflexive and dynamic process of labour, using interventions appropriately.

Integrated experts subtly integrate the art and science of midwifery. Integrated experts appear to do more than accommodate the differences in culture, they appear to influence it. By utilizing their depth of knowledge and experience, integrated experts have the capacity to create optimal birth for women and may be regarded as valuable role models. If we are able to identify and learn from these experts, it may be possible to challenge practice, in order to accommodate or overcome the dissonance between different models of practice. This would in turn benefit the profession in terms of recruitment, retention and professional status.

At opposite ends of a continuum, physiological experts are fundamentally expert in low risk home birth, community, or birthing centre settings. However, their competence and confidence appears to be challenged when taken out of a low risk

setting. Thus, the birth environment, and culture and practice within that environment may influence physiological expertise. At the other end of the continuum, technical experts appear to be skilled in using equipment and birth technology. Technical experts may be considered advanced practitioners undertaking ventouse delivery, those performing ultrasound scanning, or assisting with caesarean sections. Again, technical experts demonstrate expertise in a high risk setting, and their expertise may be challenged if they were to work outside their usual domain of practice. However, it must be acknowledged that physiological and technical expertise received little focus from participants. The findings have been based on anecdotal evidence and peripheral findings from other sources and would require further exploration in subsequent studies.

14.0 Study Conclusions

Data from this study have identified three domains of expert midwifery practice; 'physiological expertise', 'technological expertise', and 'integrated expertise'. Integrated expertise appears to be the most dominant finding in this study. Integrated experts appear to transcend the boundaries of normality and pathology, negotiating the pull between the active management and expectant management of labour, navigating the dichotomy between the medical and holistic model of care and may be defined as;

'the intrapatum expert possesses the essential personal characteristics, and demonstrates the necessary skill and ability to promote normal childbirth, to recognise deviations from the norm and to use technological interventions appropriately in order to facilitate optimal birth outcomes for childbearing women, and to fulfil the emotional, physical and spiritual needs of the woman and her family in any setting. Integrated experts respond dynamically to a range of settings, positively influencing the setting and those working within it'.

Both physiological expertise and technical expertise appear to be two distinct paradigms of expertise at opposite ends of a continuum. At each end, experts demonstrate particular skills in either low or high risk care, with the practitioners' ability to demonstrate this expertise being influenced by the clinical environment in which they work. This appears to be an important characteristic that differentiates them from integrated experts.

Four main themes (wisdom, skilled practice, enacted vocation and connected companionship) have been identified through the study as fundamental concepts of intrapartum maternity care expertise. Findings suggest that all expert intrapartum maternity care practitioners will demonstrate particular aspects of wisdom, skilled practice, enacted vocation and connected companionship.

Within the concept of wisdom, the study suggests that expertise is more than intellectual knowledge. Expert practice appears to be defined by the ability to reflect

on, integrate, internalize, critically analyse and apply knowledge gained through education and experience in a variety of settings in order to provide optimal holistic midwifery care. These findings appear to resonate with other studies exploring the nature of expertise (Jasper 1994; Paul & Heaslip 1995; Edwards 1998; Benner 2001; Christensen & Hewitt-Taylor 2006a; Christensen & Hewitt-Taylor 2006b; Ericsson 2007).

Within the domain of enacted vocation, experts appeared to value the caring, nurturing aspect of practice. They appear to place emphasis on values such as trust, empathy, belief, and courage. These concepts appeared to be fundamental to the way they facilitated holistic care. Experts were reported to have both a fundamental trust and belief in birth, and in women's ability to give birth. Thus giving women time and a safe space in which to labour and birth. Findings suggest that experts subtly integrate the art and science of midwifery, embodying or enacting the values and ideals of the profession.

Experts were suggested to value connected relationships with women and colleagues. This relationship was founded on mutual respect, honesty and trust. The midwife-woman relationship was suggested to be facilitated through giving women time, listening, and through effective communication and presencing. Being present often entailed being in the room, but not doing anything physical. This enabled the expert to become 'in-tune' or connected with the woman, allowing her to watch and observe subtle changes or patterns in the woman's behaviour or in the pattern of labour. This facilitated her ability to make intuitive judgments or decisions. These findings appear to resonate strongly with the helping role proposed by Benner (2001).

Within the domain of skilled practice, integrated expertise appears to be more than the ability to demonstrate technical brilliance, but in the selective and appropriate use of interventions. Technology appears to be secondary to the experts' fundamental midwifery skills. Findings suggest that experts are dynamic; demonstrating the ability to negotiate or adapt care to fit the unpredictable patterns of labour and birth. Decision making is often intuitive. The expert is able to draw on his/her pool of knowledge and experience, to instinctively make a decision. Experts were reported to be intuitive, predominantly use their senses; their hands, eyes and ears, when making

judgements and decisions. Findings suggest that experts are skilled in their ability to anticipate, recognize and respond to deviations from normal, often before the problem has occurred. Again, these findings resonate with the nursing literature surrounding expertise (Paul & Heaslip 1995; Edwards 1998; Benner 2001; Christensen & Hewitt-Taylor 2006b).

Expert practitioners were suggested to be competent, confident and skilled in their area of practice. However it appears to be within the domain of skilled practice which determines where on the continuum of expertise the practitioner is situated. This is depicted by the model proposed on page 116. Thus, if practitioners are regarded experts in their technical ability, they will be placed within the domain of technical expertise. If experts are identified by their skill and expertise in promoting physiological birth, then they will be situated within the domain of physiological expertise. Those experts who are identified at being skilled in both areas will be situated in the central domain of expert practice. Findings suggest that these domains are not fixed, and that practitioners can move freely along the continuum. However, this would require further exploration in subsequent studies.

It appears that one significant difference between the domains of expertise is the effect that the environment has on expert practice. Findings of this study strongly support the argument that the clinical environment, and the practices and philosophies within that environment, do not affect the practices of integrated experts. Integrated experts are suggested to subtly negotiate these different environments, and play a significant role in shaping and influencing these environments. In contrast, both physiological experts and technical experts are suggested to demonstrate expertise in their own specific domains of practice. Although their practice is suggested to influence their working environment, their practice is also suggested to be influenced by that environment. However, this would require further exploration in subsequent studies.

Data from this study adds new insight to the nature of expertise. The significance of having the right attitude appears to be a new phenomenon to the nature of expert practice. Vocational attributes such as being kind and caring, having a fundamental trust and belief in women and birth, and demonstrating qualities such as motivation,

courage and commitment was equally as important to skill and competence. Findings suggest that the attitude of the health professional could significantly affect birth outcomes, and women's experiences of care. However, further research would be required to explore this concept further.

Findings from this study appear to resonate with the findings of literature surrounding nursing and medical expertise. However, it must be acknowledged that the findings relating specifically to the context of midwifery care reflect what Davis-Floyd (1987) has identified as the contemporary Western birth culture. Thus, in developing countries it may be that different skills or types of expertise may be more significant in averting maternal and neonatal morbidity and mortality rates (Carlough & McCall 2005). Further cross-cultural research would be required to explore this.

Findings suggest that the culture of the birth environment has a significant impact on both the midwifery profession, and expert intrapartum care. From a phenomenological viewpoint, *'childbirth is a complex life event characterised by rapid biological, social and emotional transition'* (Blaaka & Schauer 2007 pg 7). However, maternity care appears to have become technologically driven. Literature suggests that many midwives' appear to have lost sight of the fundamental, vocational aspects of midwifery in their pursuit towards professional recognition. However, findings from this study propose that vocational qualities such as trust, caring and nurturing are fundamental to expert practice.

Findings suggest that many participants remain unclear about aspects of normal birth, and the use of interventions within the context of physiological childbirth. Despite the professional strive towards physiological birth, which has been described in this study as the professional project of midwifery, participants in this study appear unclear about the boundaries of, and nature of normal childbirth. Indeed the use of, and acceptance of interventions within so called normal childbirth appeared to cause much debate for participants in this study. There appear to be three evident arguments in the data, the first being what constituted an intervention, the second being which of those interventions are acceptable within normality, and the third being how these two are mediated by the professional who carries out the intervention.

These findings are not a new phenomenon. The definition and practice of normal childbirth continues to cause much debate amongst health care providers (Beech 1997; WHO 1997; Downe 2001; Downe et al 2001; Page 2003; Sandall 2004; Thompson 2004). As midwives' claim to be the experts in normal childbirth, this consequently raises issues surrounding the legitimacy and practice of midwifery, and expertise in this area. Participants also alluded to the challenge of working between contrasting models of care including the medical, technological, social and holistic model. This was reported to place midwives' under considerable emotional stress and pressure. Similar findings have also been observed across the wider midwifery spectrum, where many midwives' are reported to be leaving the profession due to increasing levels of burnout and stress (Curtis et al 2006). These issues raise considerable concern in a profession that already faces the pressure of staff shortages, low morale, low retention and low recruitment.

However, findings from this study suggest that expert intrapartum practitioners demonstrate the ability to challenge and overcome these cultural and professional problems. They are argued to be courageous, demonstrate leadership qualities, being successful in their ability to motivate, encourage, and inspire others. Experts are fundamental to making changes happen. One significant quote from the study to support this argument is; 'and *she just undid that eighteen months, which was really good"* (GI MLU D). This quote depicts how working with the expert and observing her practice, allowed the practice of one midwife to become transformed. The term 'just undid' represents the power and dynamism that experts have, and the powerful position they have over influencing, changing and promoting expert practice. Therefore using experts as role models may be argued to be an effective way of improving practice, challenging cultural norms, and promoting evidence based care.

14.2 Recommendations

Findings from this study have suggested that expert practice is developed through the integration and utilisation of knowledge, experience, and education. Experts were noted to demonstrate both technical and fundamental skills, to be both confident and competent, to be skilled in their judgment and decision making ability, to have a fundamental belief and trust in women, birth, and intuition, and to be courageous in

challenging practice and protecting women. They were also held to be skilled in their ability to establish relationships with women and colleagues, thereby creating an environment of trust.

When reflecting on all the characteristics and skills that denote expert practice, several recommendations may be suggested which may be used in practice:

1. Reflection

Data from this study suggest that reflection is a powerful tool that facilitates expert practice. Maintaining a reflective journal or log of clinical scenarios would allow practitioners to explore aspects of practice such as decision making. Reflection may be personal, or shared as part of a group process, allowing knowledge and skills to be shared and developed. Sharing stories from practice would allow for examples of good practices to be cascaded.

2. Experts identified as role models

This study suggests that expert intrapartum midwives demonstrate characteristics and skills that facilitate optimal birth experiences and optimal birth outcomes for women and their babies. This study also demonstrates that experts have the potential to change, influence and improve midwifery practices.

The findings also suggest that 'who you see', and the practices you observe as a student significantly affect practice once qualified. Therefore, one recommendation from this study would be that expert practitioners are recognised and acknowledged for their skill and ability, and formally identified as role models for other midwives or student midwives. However, further research would be required to enable experts to be identified in practice. A questionnaire is currently being undertaken by the research team to explore this area of research, in order to develop a tool which may be used as part of the selection, recruitment or appraisal system of midwives, in an attempt to identify potential experts in practice.

3. Further research

It is recommended that further research is required to explore the specific domains of expertise (physiological, integrated and technical) proposed in this study. Further research is planned in this area.

The findings cannot be generalised to countries where the most important concern in maternity care is maternal mortality. Different skills or types of expertise may be more significant in averting maternal and neonatal morbidity and mortality rates (Carlough & McCall 2005). Further cross-cultural research is also planned in this area.

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Appendix One

Published literature review

JAN REVIEW PAPER

Expert intrapartum maternity care: a meta-synthesis

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Abstract

Title. Expert intrapartum maternity care: a meta-synthesis

Aim. This paper reports a meta-synthesis exploring the accounts of intrapartum midwifery skills, practices, beliefs and philosophies given by practitioners working in the field of intrapartum maternity care who are termed expert, exemplary, excellent or experienced.

Background. Expertise in nursing and medicine has been widely debated and researched. However, there appear to be few studies of practitioners' accounts of expertise in the context of maternity care. Given current international debates on the need to promote safe motherhood, and, simultaneously, on the need to reverse rising rates of routine intrapartum intervention, an examination of the nature of maternity care expertise is timely.

Method. A systematic review and meta-synthesis were undertaken. Twelve databases and 50 relevant health and social science journals were searched by hand or electronically for papers published in English between 1970 and June 2006, using predefined search terms, inclusion, exclusion and quality criteria.

Findings. Seven papers met the criteria for this review. Five of these included qualified and licensed midwives, and two included labour ward nurses. Five studies were undertaken in the USA and two in Sweden. The quality of the included studies was good. Ten themes were identified by consensus. After discussion, three intersecting concepts were identified. These were: wisdom, skilled practice and enacted vocation.

Conclusion. The derived concepts provide a possible first step in developing a theory of expert intrapartum non-physician maternity care. They may also offer more ` general insights into aspects of clinical expertise across healthcare groups. Maternity systems that limit the capacity of expert practitioners to perform within the domains identified may not deliver optimal care. If further empirical studies verify that the identified domains maximize effective intrapartum maternity care, education and maternity care systems will need to be designed to accommodate them.

Keywords: expertise, maternity care, meta-synthesis, midwifery, nursing, qualitative research, systematic review

Introduction.

Basic competencies for intrapartum care have been described for trained midwives (International Confederation of Mid-wives 2005), and for intrapartum carers in general (Safe Motherhood: Family care international 2002). A recent paper has described the attributes of the 'good' midwife (Nicholls & Webb 2006). However, there do not appear to be any

agreed characteristics for non-medical experts in maternity care settings. This has particular significance in the intrapartum period, given the potential for mortality, morbidity and for the promotion of maternal and infant wellbeing. In this paper we explore this topic as the first step of a planned programme of work.

Background

Millions of women give birth every year. While the vast majority experience childbirth safely, hundreds of thousands do not, especially in low-income countries (Betran *et al.* 2005). This has led to international debate about safe motherhood. Paradoxically, the dominant world-wide risk averse approach to childbirth has been criticized for generating a significant rise in unnecessary intrapartum interventions, and, especially, caesarean section (World Health Organisation: Department of Reproductive Health and Research 1997). So-called 'skilled care' has been proposed as a solution to both the safety and the excessive intervention issues (World Health Organisation: Department of Reproductive Health and Research 1997, Safe Motherhood: Family care international 2002). While most authorities agree that universal provision of licensed, educated or trained midwives would be optimal, economic necessity has led to an acceptance that traditional birth attendants (also termed parteras), may be a pragmatic solution in some contexts (Kruske & Barclay 2004). A perceived need for extra support during labour has also led to the rise in so-called doulas, who offer companionship and advocacy to childbearing women, with or without formal training (Ballen & Fulcher 2006).

In some jurisdictions, such as the UK, the only practitioners able to take clinical responsibility for labouring women are medical doctors, and those who have been formally educated and licensed as midwives (Nursing and Midwifery Council 2004). In other legislatures, such as the US, there is a plurality of provision (American College of Nurse Midwives (ACNM) 2005, MANA 2006). We were interested in exploring expert non-medical intrapartum care in the context of this range of provision.

There is a substantial body of literature around expertise for medical practitioners (Custers *et al.* 1996, Eraut & Du Boulay 2001) and for nurses (Benner 1984, Benner *et al.* 1996, Price & Price 1997). However, we could not locate any authoritative research-based texts on non-medical intrapartum expertise. Our aim, therefore, was to examine this topic through studies of intrapartum practitioners who were termed expert, exemplary, excellent, or experienced. Although we knew of many quantitative studies exploring optimal maternity care practices, they tended to be designed to assess the clinical outcomes of specific aspects of care, such as 'continuity', or the predictors of positive outcome, such as women's satisfaction with care (see, for example, Nicholls & Webb 2006). We limited our search to qualitative studies as we aimed to undertake a very focused review of a specific attribute ('expertise') from the perspective of individual caregivers themselves, and not as predefined by professional projects, researchers, or policymakers. We believed that this would permit an interpretation of maternity care expertise that was as unimpeded as possible by taken-for-granted assumptions, as well as offering the potential to reveal any possible conflicts in perceptions of expertise within and between maternity care groups. Given the capacity of qualitative designs to capture rich individualized data, we designed our study as a meta-synthesis.

We did not limit the inclusion criteria to a specific professional group, in recognition that a range of non-medical practitioners provide intrapartum care across the world. This was in keeping with our desire to look at the notion of expertise in this area without the assumptions brought by specific professional projects. During our thematic analysis, we used the techniques of reciprocal and refutational translation to look for similarities and differences between studies (and thus between professional groups).

Search methods

The research comprised a systematic review and a meta-synthesis. We included all relevant English Language research published between 1970 and June 2006. The decision to commence the search in 1970 was based on the move of childbirth from the home setting to hospitals. This move became marked in high income countries in the 1970s (Arney 1982, Tew 1998). Hospitalization has influenced maternity care provision, and the use of birth technologies, across the world. For example, caesarean section is now the standard mode of birth for some communities in Brazil (McCallum 2005). We concluded that this changing context of maternity care would limit the applicability of studies published before 1970.

The research question was:

What accounts of intrapartum midwifery skills, practices, beliefs and philosophies are given by practitioners working in the field of maternity care who are termed expert, exemplary, excellent or experienced in intrapartum maternity care

In the text below we have used the term 'beyond the ordinary' as a pragmatic shorthand for 'expertise', 'exemplary' 'excellent' and 'experienced'. Our definitions and exclusion criteria are given in Table 1.

Table 1 Definitions and exclusion criteria

Definitions

Term	Explanation
Qualified midwife	Qualified and licensed midwives
Midwifery student	Students studying courses that meet the criteria for licensing as midwives
Nurse	Qualified and licensed nurses who work in an intrapartum setting but who are not qualified and licensed as midwives
Nurse-midwife	Qualified and licensed nurses who are also qualified and licensed as midwives
Lay midwife	Experienced clinical practitioners who practice intrapartum care, but who are not formally licensed as midwives.
Traditional birth attendant, partera, dai	Experienced local women who practice intrapartum care, but who are not formally licensed as midwives or nurses
Doula	Labour supporters who are not trained or licensed in clinical midwifery practice, but who may have received specific formal training in techniques of labour support
Beyond the ordinary	A high level of knowledge or skill: studies where any of the following terms are used to describe the participants: expert, experienced, exemplary
Exclusion criteria	• Opinion papers • Research that only resulted in quantitative data • Participants not maternity care practitioners according to the definitions above • Participants not identified as '*beyond the ordinary*' according to the definition given above • Papers focused *a priori* on specific aspects (such as intuition) or narrow areas of practice (such as using the ventouse, or undertaking episiotomy) • Studies with inadequate information to establish the quality of the research.

We searched 12 databases, hand searched five journals and regularly scrutinized the contents pages of a further 45 relevant health and social science journals (see Box 1 for details). We contacted relevant e-groups and experts for grey literature. A full list of the initial and final search terms used, and resources searched, is available from the authors. The

Box 1 Sources for search

Databases/search engines
  CINAHL
  Allied and Complementary Medicine
  British Nursing Index
  EMBASE
  MEDLINE
  Ovid MyJournals
  AMED
  BIDS
  ASSIA
  ProQuest
  Midwives Information and Resource Service (MIDIRS)
  National Research Register
Journals handsearched
  British Journal of Midwifery
  Social Science & Medicine
  Midwifery
  Birth
  Journal of Advanced Nursing

Contents pages of 45 other relevant health and sociology journals were searched regularly via Zetoc (details available from the lead author).

quality criteria for including studies were based on the Critical Appraisal Skills Programme (CASP 2002) and on Walsh and Downe (2006).

The reviewing process

The process of reviewing was highly iterative and revisionist (Walsh & Downe 2005). It was closely aligned to qualitative constructionist epistemologies.

Stage 1. Title, abstract and full text review
Two members of the team (LS, KT) independently undertook the search. The total hits amounted to over 15,000. For the overwhelming majority of these papers the titles indicated that they were either not relevant to the study, were not qualitative research papers, or did not include participants meeting our definition of 'beyond the ordinary'. These titles were excluded. Where this was not clear, the abstract was reviewed. After extensive discussion between all three authors, full text papers were obtained for seventeen studies (Table 2). They were initially reviewed blind to each other by LS and KT. Differences in opinion were mediated by SD. The quality of the remaining papers was blind assessed using the Critical Appraisal Skills Programme criteria (CASP 2002). This covers three areas, namely rigour, credibility, and relevance, using ten prompt questions. Ten papers were excluded at this stage. The primary reason for exclusion is given in Table 2.

Table 2 Studies identified after abstract review: final inclusion and exclusion

Author, date	Final decision	Reason for exclusion
Davis-Floyd and Davis (1997)	Excluded	No indication that the participants were 'experts'
Guiver (2003)	Excluded	No indication that the participants were 'experts'
Shallow (1999)	Excluded	No indication that the participants were 'experts'
Konstantiniuk *et al.* (2002)	Excluded	Only quantitative data
Stamp (1997)	Excluded	Only quantitative data
Patrick (2002)	Excluded	Only quantitative data
Alexander *et al.* (2002)	Excluded	Specific to ventouse practitioners
Butterworth and Bishop (1995)	Excluded	Only 13% of participants maternity care practitioners
Kennedy *et al.* (2003)	Excluded	Meta-synthesis of American studies (one relevant paper included in this review)
Sookhoo and Biott (2002)	Excluded	Insufficient data to assess quality
Sleutel (2000)	Included	
Kennedy (2000)	Included	
Berg and Dahlberg (2001)	Included	
Lundgren and Dahlberg (2002)	Included	
Kennedy (2002)	Included	
James *et al.* (2003)	Included	
Kennedy (2004)	Included	

Stage 2. Detailed quality review of included studies

A detailed quality assessment based on the checklist of Walsh and Downe (2006) was undertaken for the remaining seven studies. This assesses the appropriateness and coherence of the study scope and purpose, design, sampling strategy, analysis, interpretation, researcher reflexivity, ethical dimensions, relevance and transferability. A summary score was then allocated (see Table 3 for details). A full account of the quality assessment of each study is available from the authors.

Analysis

The analysis involved the following stages: compare and contrast metaphors, phrases, ideas, concepts, relations and themes in the original texts; undertake reciprocal and refutational translations to establish how far the themes arising from the included studies were similar, or different; then synthesize the themes arising from the preceding steps (Noblit & Hare 1988, Walsh & Downe 2005). For each step, we undertook the analysis separately. We agreed on the final analysis by consensus.

Results

Characteristics and quality of included papers

Five of the included studies were undertaken in the USA. Three of these were by the same author. Although each paper contains a report of a different study, a sub-set of the participants appears to overlap all three studies. Two studies were from Sweden, both with the same second author but reporting different studies, with no apparent overlap of participants. Participants included nurses, nurse–midwives and midwives. The quality was generally good, with some weaknesses in the use of techniques to ensure the transparency of the analysis, and in reflexive accounting.

Findings

We initially identified 13 themes from the data (see Table 4). After discussion, we agreed that the data separated out under 'connection' and 'companionship' was of a similar order, and these were combined into one theme (connected companionship). We also noted that, as well as the original value of 'trust' there were values relating to belief (in normal birth, and in women's bodies), and to courage. The original theme of trust was therefore expanded into a theme of 'value'. We noted that issues of role change, profession, and of accommodation to adverse external forces were more about process and context than expertise. We combined these into a parallel concept termed *'reaction to the context of childbirth'*. The 10 themes remaining in the analysis were then subject to synthesis. Three overarching domains were identified: wisdom, skilled practice and enacted vocation. Nurses, nurse–midwives and midwives were represented in each of these domains.

Table 3 Characteristics and quality of included studies

Criteria	Sleutel 2000, USA	Kennedy 2000, USA	Kennedy 2002, USA	Kennedy 2004, USA	James et al. 2003, USA	Berg & Dahlberg 2001, Sweden	Lundgren & Dahlberg 2002, Sweden
Scope and purpose	To describe labour support techniques and strategies to enhance labour progress and prevent caesarean births. Fair links with literature	'to describe exemplary midwifery practice. Extensive theoretical literature cited.	Study undertaken 'as a means of corroborating' findings from Kennedy 2000. Very little literature cited	'to expand knowledge on the processes and outcomes of midwifery care'. Both directly relevant and theoretical literature cited	'to examine how expert perinatal nurses...view their role in caring for mothers during labour and birth'. Some directly relevant literature cited	To describe how midwives experience the care of women who are at high obstetric risk or who have an obstetric complication... Range of directly relevant and theoretical literature cited	To describe midwives experience of the encounter with women and their pain during childbirth. Large range of relevant literature cited
Design, methods	Interpretive interactionism. Termed a 'pilot study'. Observation and interview	Theoretical framework feminist, and emancipatory. Delphi study	'qualitative'. Videotaped interviews	Theoretical framework not explicit. Videotaped interviews	Theoretical framework not explicit. Tape recorded focus groups	Phenomenology. Tape recorded interviews	Phenomenology. Tape recorded interviews
Sampling strategy Participants	One labour and delivery ward with 70–100 births/month (Oct 1998–March 1999). Not clear why hospital was selected. One participant interviewed: criteria: min 3 years experience labour and delivery, graduate or equiv level, 'nurturing, caring demeanour' ('expert'). Demographics not given	Midwife participants: Midwives who had been honoured for excellence by the ACNM CNM's nominated as 'exemplary' (expert, and excellence, also used in some places in the text) by: – leadership of ACNM and – a stratified random sample of 62 nurse midwifery service directors across the US Midwives nominated by the leadership of MANA. $n = 64/142$ nominations for first round, 52 completed all three rounds) Participants were distributed across 6 ACNM regions of US, 1 from Canada. Years experience 1–45. Age range 39–73. 90% Caucasian. 73% college graduates, 70·5% masters degrees. A variety of birth settings represented. Range of births 3–184 annually	11 'expert' midwives from original 64 in the Delphi study (Kennedy 2000). Not clear why these 11 were selected. Age range 49–62; years in practice 6–29. 64% masters level education. Most worked in hospital: 2 attended home births, and 2 worked in birth centres.	14 midwives (and 4 recipients of care, not included in this review). 11 from original Delphi study (Kennedy 2000). It is not clear if these participants were those in Kennedy 2002. 3 midwives 'theoretically sampled based on emerging findings'. Years in practice 6–40. Practiced in ' a variety of settings'.	4 'large mid western' hospitals (births per annum 2800–6500). Selected because nurse-managed labour was the practice model. 8 focus groups 54 nurses: 'at least 5 years intrapartum experience'. Demographics: range of years of experience 5–38 Hospitals: rates of intervention higher than in US national statistics	Four hospitals where the care of women at high obstetric risk was differentiated from care of other women 10 midwives (of 11 invited) with at least 5 years experience, and recognized as being 'highly skilled clinicians'. Demographics: age range 41–52, 9–29 years midwifery practice (5–8 years 'high risk').	'Experienced' midwives ($n = 9$) in two hospital settings in Sweden. Not clear why these settings were chosen. Participants chosen as 'experienced' by the head midwife at both sites. Demographics: age range 38–52, 12–28 years midwifery practice.

Table 3 (*Continued*)

Criteria	Sleutel 2000, USA	Kennedy 2000, USA	Kennedy 2002, USA	Kennedy 2004, USA	James *et al.* 2003, USA	Berg & Dahlberg 2001, Sweden	Lundgren & Dahlberg 2002, Sweden
Analytic strategy	Emergent, iterative Examples given of how analysis evolved, large amounts of data provided. Triangulation between participants' account and observational data Some evidence of saturation (though only one participant): evidence of accounting for disconfirming data. Participant and external expert verification of findings noted	Content analysis, using NUD*IST, and measures of central tendency using SPSS. Data triangulated between qualitative data and ranking statements. Not clear if saturation was reached, or if disconfirming data were sought and accommodated. On-going analysis verified with a research jury.	Emergent, iterative, using constant comparative analysis, based on grounded theory Not clear if saturation was reached, or if disconfirming data were sought and accommodated. No mention of participant or external verification of findings	Narrative analysis using Atlas ti, and based on codes and themes. Findings triangulated with Delphi findings The authors state that they reached data saturation. It is not clear if disconfirming data were sought and accommodated Analysis undertaken by all four authors collaboratively. The final synthesis was also discussed with experienced researchers outside the research team. The process is fully explained	Inductive coding & thematic methods of analysis Findings triangulated between the four centres Data saturation and a search for disconfirming data not noted. Analysis undertaken by research team and 'two independent' researchers.. Findings reviewed by 3 focus group participants.	Analysis used method described by Giorgi 1997. This involved the identification of meaning units, transforming the meaning units, synthesizing and summarizing, and the formulation of a general structure of the phenomenon. Triangulation not apparently part of the method. Not clear if saturation or disconfirming data sought. No mention of participant or external verification of findings (although the first author notes that '*the other researcher was not a midwife which contributes to objectivity*'.	Analysis used method described by Dahlberg *et al.* 2001: reading and re-reading text, identifying 'meaning units', unpacking the meaning of the text, and relating the meaning units to each other. The 'subjects naive description' was then transformed into 'language meaningful for midwifery'. Triangulation not apparently part of the method. Not clear if saturation or disconfirming data sought. No mention of participant or external verification of findings (although the authors state '*the interviews were 'primarily' analysed by the interviewer*).
Quality rating	B	A	B	A	B	B	B

Key to quality rating: A, no or few flaws. The study credibility, transferability, dependability, and confirmability[33] is high; B, some flaws, unlikely to affect the credibility, transferability, dependability, and/or confirmability of the study; C, some flaws which may affect the credibility, transferability, dependability, and/or confirmability of the study; D, significant flaws which are very likely to affect the credibility, transferability, dependability, and/or confirmability of the study.

Table 4 Emerging themes and concepts

Themes, first iteration	Themes, final iteration	Core concept	Relevant papers
Education	Education through training	Wisdom	Kennedy (2000)
Experience	and experience		Berg and Dahlberg (2001)
Knowledge	Knowledge		James *et al.* (2003)
Competence	Reflexive competence	Skilled practice	Sleutel (2000)
Confidence	Confidence		Kennedy (2000)
Judgement	Judgement		Berg and Dahlberg (2001)
Skills	Technical skills		Kennedy (2002)
			Lundgren and Dahlberg (2002)
			James *et al.* (2003)
			Kennedy (2004)
Trust	Values (belief, courage, trust)	Enacted vocation	Sleutel (2000)
Intuition	Intuition		Kennedy (2000)
Connection/	Connected companionship		Berg and Dahlberg (2001)
companionship			Kennedy (2002)
			Lundgren and Dahlberg (2002)
			Kennedy (2004)
			James *et al.* (2003)
Role changes	Role changes	Parallel concept: Reaction	Sleutel (2000)
'Profession'	'Profession'	to context of childbirth	Kennedy (2000)
	'ironic intervention'		Berg and Dahlberg (2001)
			James *et al.* (2003)

Summary of domains and themes

Wisdom

Education through training and experience. There was very little reference in the studies to formal midwifery or maternity care education. It seemed to be taken for granted as a core requirement. The more important capacity seemed to be the ability to reflect on and integrate both experiential and formal education into a basis for on-going knowledge development. James *et al.* (2003) term this process *'the ability to use the past in the present'* (p. 818).

The quality and diversity of education and experience, coupled with the reflective capacity of the practitioner, enabled the development of expert practice. Further, expert learning encompassed a kind of intellectual curiosity (Kennedy 2000), a continuing search for more educational opportunities, and an intelligent questioning of the taken for granted.

Knowledge. Berg and Dahlberg (2001) note the expert's ability to accommodate both embodied and theoretical knowledge. They refer to *'sensitive knowledge'* (p. 263) and *'sensitivity for the spontaneous'* (p. 261). These phrases express the capacity of the midwives in their study to demonstrate *'a developed ability to use ones senses'.* As one of their respondents says:

I have to hear what she is saying. I have to hear, I have to feel, absorb what it is she wants, what she's afraid of, what she is going through...I can feel it in the air, fell it in the vibrations, you can see it in her body language, hear how she breathes, speaks (p. 263)

James *et al.* (2003) note that labour care nurses displayed *'the intuitive nature of nursing care* (p. 818)'. This was bound up in an intimate knowing about the process of labour built up by years of experience, and underpinned by *'deep understanding'.* Knowledge was not a superficial consequence of book learning, but a much more deeply felt and expressed consequence of consciously living with and learning from birth:

Expert nurses were open to rethinking a situation, emphasizing the importance of constantly assessing and reassessing a woman's labour. An expert nurse was not threatened when her planned interventions proved ineffective, or required modification (p. 819)

This illustrates an acceptance of uncertainty, and awareness that there are no 'preset patterns' in birth. Eraut (1994) has hypothesized that there are two types of professional knowledge. Type A (public knowledge) is subject to external quality control and built into educational programmes, examinations and qualifications. It is about knowing that, not knowing how. Type B (professional personal knowledge) is a synthesis of both knowing that, and knowing how. This appears to be expressed in the papers included in this section.

Synthesis. The two themes in this section seemed to coalesce into something that was beyond intellectual knowledge, repeated years of experience, or book-learning education. This led us to the concept of wisdom. Although some nursing theorists (Lauder 1994, Litchfield 1999), and alternative midwifery publications (Tritten 1992) have paid attention to wisdom, it appears to have fallen out of favour recently. The following quote summarizes the way in which we want to use the term:

Wisdom is a state of the human mind characterized by profound understanding and deep insight. It is often, but not necessarily, accompanied by extensive formal knowledge. Unschooled people can acquire wisdom, and wise people can be found among carpenters, fishermen, or housewives. Wherever it exists, wisdom shows itself as a perception of the relativity and relationships among things. It is an awareness of wholeness that does not lose sight of particularity or concreteness, or of the intricacies of interrelationships. (Meeker 1981)

Skilled practice

Reflexive competence. The classic analysis of Benner proposes that the route to expertise starts as a novice, and progresses through the competence and proficiency (Benner 1984). However, controversy surrounds the concept of competence (Worth-Butler *et al.* 1995). At the basic level, this may mean only the performance of routine clinical skills according to standard procedures and guidelines. In contrast, the skills noted in Kennedy's (2000, 2002) studies suggest dynamism and contingency:

When you bump the boundaries (of normal) my job is to gently guide you back...I was a guest, and I was invited to be an expert, but only if they needed me to be one. (Kennedy 2002, p. 1759)

This speaks of a reflexive competence that can deal with uncertainties and rapid changes in labour, and which is not dependent on standard protocols, and routine techniques. Kennedy suggests that the expert midwife *'orchestrates labour'*, and *'creates/manoeuvres the birth space for women'* (Kennedy *et al.* 2004). This is an active process that provides a kind of guardianship. It creates what Walters and Kirkham (1997) have termed a *'safe space in which the mother is the main actor'*.

All of the authors of the studies included in our meta-synthesis noted that the experts in their studies needed to be skilled in clinical techniques. However, they also seemed to possess anticipatory and preventative competence. They predicted likely events, both in the labouring women, and in the surrounding environment, and worked with these predictions to optimize outcomes. This allowed them to let go

of the births they attended: paradoxically, in being the experts, they no longer needed to claim their expertise. As James *et al.* (2003) state, they were able to *'let the woman own the labour'*. Lundgren and Dahlberg (2002) express something similar when they comment that the practitioners in their study *'met the woman as a unique individual in an open-minded way'*. However, they were also highly responsive to pathology when necessary, *'seizing the women'* when they found that labour exceeded their ability to cope.

Confidence. A person who is objectively competent may lack confidence in their abilities, and an over-confident person may over estimate their capacities. Generally, however, confidence and competence did co-exist in this review. Kennedy (2000) noted that the midwives in her study had the confidence to make decisive decisions. In a later study (Kennedy 2002), there is a rather different construction of confidence, termed *'the art of doing 'nothing' well'*. This phrase expresses a confidence to not act. The contingent nature of acting or not acting echoes the points made above about reflexive competence. As James and colleagues state:

The confident nurse stepped away from the technology and towards the woman. (James *et al.* 2003, p. 819)

Berg and Dahlberg (2001) note that the midwives in their study undertook 'balancing' in a number of areas, including the facilitation of mutual confidence with the medical staff. While this appears to be a benign observation, in some cases friction between different philosophies of labour led to practitioners acting in ways which did not reflect their beliefs about birth, and which potentially undermined their confidence in their particular expertise (Sleutel 2000, Berg & Dahlberg 2001). These aspects are explored in more detail below under *'Reaction to context of childbirth'*.

Judgement. From a risk-aversive perspective, the more complex a judgment needs to be, the more likely it is an error will be made. The main justification for the production of protocols, guidelines and nomograms is to minimize these risks. However, an adverse consequence of this increasing standardization is a restriction of creativity, and a decreased capacity to respond to and innovate in novel situations. Eraut and Du Boulay (2001) note that professional experts often have to take decisions in situations that are ill-structured, uncertain, shifting, subject to high stakes, involve multiple players, and that are contextualized by time stress and organizational goals and norms. Arguably, labour consistently demonstrates these characteristics. Expert maternity care practitioners therefore have to negotiate both the

uncertainty and complexity of the actual process of labour as well as negotiating the organizational and inter-professional hurdles that accompany maternity care in the twenty-first century. This was particularly evident in the study of Sleutel, where the key concept was that:

Intrapartum nursing care reflected both a medical model of controlling and hastening birth, as well as a supportive, nurturing and empowering model of practice that used independence, clinical judgements, and advocacy. (Sleutel 2000, p. 38).

In two of the studies, judgement is both a result of independent decisions by the practitioners, and of accommodating external forces, such as *'dealing with the pressures to speed up the labour process'* (James *et al.* 2003), or of using one set of interventions to avoid more invasive procedures (Sleutel 2000). Where practitioners were free to make judgements on the basis of labour itself, these decisions were made along a spectrum that was conceptualized by Lundgren and Dahlberg (2002) as *'waiting for the woman'* at one extreme, and *'seizing the woman'* at the other. The expertise lay in balancing these two extremes, and in setting up and judging the labour (termed *'orchestrating'* by Kennedy (2002) so that overt decision-making that interrupted the flow of the birth only needed to happen when pathology was unavoidable.

Crucially, the use of expert skills was framed by an acceptance of accountability for the judgments made (Kennedy 2002).

Clinical skills. Skills encompassed both technical capacity, and emotional intelligence. Technical skills were evident in both the use of equipment and emergency procedures, and, more subtly, in keeping birth physiological (Sleutel 2000, Kennedy 2002). James *et al.* (2003) note that practitioners could call upon a *'bag of tricks'*. These included *'technological skills and judgment*, and *'hands on, high touch supportive care techniques'*. While touch can be positive or negative (Kitzinger 1997, El-Nemer *et al.* 2005), in James and colleagues study it was clearly framed as supportive, and protective of physiological processes. Clinical skills included observation, assessment, and positioning of the woman (Sleutel 2000), and reading women's bodies without resorting to external measurement and machine recordings (Lundgren & Dahlberg 2002). Emotionally supportive skills included warmth, nurturing, gentleness, kindness, caring, and positive encouragement (Kennedy 2000, Sleutel 2000, Berg & Dahlberg 2001, Lundgren & Dahlberg 2002, James *et al.* 2003).

Synthesis. While is logical to assume that an expert is skilled in the area of their expertise, the nature of 'skill' may be less obvious. Our reading of the texts we located is that skilled

practice was made up of reflexive competence, confidence, judgement and the capacity to use technical skills. Eraut and Du Boulay (2001) note that theorists working in the area of 'naturalistic decision-making' have moved from a context-independent position of decision-making as a purely psychological process, towards one of context-dependence. For example, Lipshitz (1993) notes that decision-making is influenced by the different contexts in which the decision is made; the practitioners assessment of relevance in the particular situation; and use of complex mental imagery (such as illness scripts) as well as analytical reasoning. It may be that this is the kind of skill base used by expert maternity care practitioners. Indeed, we would theorize from our findings that some practitioners may use 'salutogenic' (described as wellbeing by Downe and McCourt (2004) scripts, as well as 'illness' scripts. In particular, this may explain some of the data in Berg and Dahlberg (2001) in the context of women at high risk. This theory remains to be tested in future research.

The subtle and complex activities that were geared around keeping birth normal included hands on-high touch techniques, the orchestration observed by Kennedy (2002), and the enactment of the *'sensitive knowledge'* noted (Berg & Dahlberg 2001). The drive seemed to be *'the struggle for the natural process'* even in the context of women at high risk (Berg & Dahlberg 2001).

Enacted vocation
Values (belief, trust, courage). Belief includes both belief in women's capacity to give birth, and in the process of childbirth as fundamentally physiological. This was expressed as *'following the mother's body'* (Sleutel 2000), *'belief in women's bodies'* (James *et al.* (2003), and *'belief that women's body was capable'* (Lundgren & Dahlberg 2002). For the women at high risk in Berg and Dahlberg's study, the authors noted the midwives' *'support of the natural processes, particularly...in apparently hopeless cases...'*. This contrasts strongly with the critique of technological childbirth processes expressed by Emily Martin (2001), who argues that modernist technocratic childbirth systems treat women's bodies as if they are faulty and need fixing.

Trust was both a consequence and a cause of the strong belief in normality. A number of the authors talk about the mutuality and reciprocity of the trust between labouring women and midwives (Berg & Dahlberg 2001, Lundgren & Dahlberg 2002, Kennedy *et al.* 2004). As Kennedy and colleagues note:

the mutuality between the midwife and the women is foundational, leading to an engaged presence by the midwife (Kennedy *et al.* 2004, p. 17).

This serves as a virtuous circle, reinforcing trust and belief in the midwife, and empowering the midwife to offer it back to the next labouring woman. As Davis-Floyd and Davis (1997) note: *'Mothers and midwives mirror one another – it's a dance – the woman has to trust the midwife and the midwife has to trust her woman for that bouncing back'* (p. 337).

The final value we located was courage. Berg and Dahlberg (2001) comment that midwives needed to be courageous to act in accordance with intuition, especially in the context of the women at high risk in their study. Similarly, James *et al.* (2003) observed that, in order to be an advocate for labouring women in a setting where there were pressures to intervene, labour ward nurses had to *'have the guts to do what you believe to be right and in the best interest of the woman and her baby'* (p. 820). Beyond the everyday need for courage in decision-making, Kennedy *et al.* (2004) notes that midwives had a *'commitment to revolutionalising systems where necessary'*. Courage also extended to an acceptance of responsibility and accountability for the consequences of actions undertaken.

Intuition. One respondent in Kennedy's first study commented that an expert midwife has *'an uncanny knowing when to step in and when to let be'* (Kennedy 2000, p. 9). The gestalt capacity for intuition is also noted in other reports (Berg & Dahlberg 2001, Lundgren & Dahlberg 2002, James *et al.* 2003). Benner deconstructed the concept of intuition in nursing practice, and concluded that *'the expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse...now has an intuitive grasp of each situation'* (Benner 1984, p. 31–32). Benner expressly refrains from seeing this process as mysterious. For her, intuitive expertise is built on the knowledge, understanding and experience that precedes the intuitive leap. For Davis-Floyd and Davis (1997), learning to trust intuition is an ongoing process, with intuitive thinking dominating as expertise increases. However, arguably, an expert midwife cannot rely on intuition alone. As Kennedy notes:

The midwives' discussion on intuition centred on a concern that the exemplary midwife cannot rely on this alone in clinical practice. It does not exempt the midwife from expert knowledge or clinical experience...'the intuitive knowledge backs up the findings as it provides the practitioner with a motive to investigate the cause'. (Kennedy 2000, p. 10)

Connected companionship. Being 'present' for the woman during the birth process but not actually 'doing' anything physical is seen as a fundamental component of the expert

midwife in Kennedy's studies (Kennedy 2002, Kennedy *et al.* 2004). Benner describes the process of 'prescencing' as being with, as opposed to doing for, a patient (Benner 1984, p. 57). Kennedy emphasizes this interpersonal connectivity by using term *'engaged presence'*. This describes more than just being present in the room with a labouring woman. It is the essence of a relationship or 'connection' the expert midwife has with the woman. Sleutel (2000) sees it as supportive, nurturing and empowering, James *et al.* (2003) and Berg and Dahlberg (2001) both talk of 'being attuned', and Lundgrun and Dahlberg (2002) of *'being an anchored companion'*. These notions of companionship are accompanied by qualities that express a relationship of profound caring. This is far removed from objective professionalism. It is also more than a maternalistic relationship, in which the midwife 'does for' the labouring woman. In order to be connected the midwife must *'know and understand'* the woman as a unique individual (Kennedy 2000), working with her as a partner in the birth process, where both midwives and woman are co-responsible (Lundgren & Dahlberg 2002).

Synthesis. The notion of vocation has fallen from favour as skilled practitioners have pursued the aim of professional credibility. However, in gaining the status of profession, with the consequent super-valuing of higher level education, the qualities and values of vocation may well have become overlooked. As the practitioners in our review became more expert, they appeared to (re)value and to express qualities such as trust, belief and courage, to be more willing to act on intuitive gestalt insights, and to prioritize connected relationships over displays of technical brilliance. This did not, however, result in denial of responsibility. On the contrary, in some of the accounts, the enactment of vocation led these experts to move outside of and beyond normative childbirth practices, and so to become more exposed to critique. Equally, while stepping back and doing less may seem to be less skilled than stepping in and doing more, Kennedy succinctly describes the expertise of enacted vocation in this way:

working to create an environment of calm, trusting in the normal birth process, and being present during labour may appear to be nothing, or inconsequential, but, in reality, it is likely to be very significant. (Kennedy 2002, p. 1760)

Parallel theme: Reaction to the context of childbirth

Role change, professional conflict and 'ironic intervention'. We have separated out this theme, as it is less to do with expertise *per se* than with the way expert practice is

moderated, or even distorted, by context. This was most strongly evidenced in Sleutel's (2000) analysis. Sleutel's key concept is that *'intrapartum nursing care reflected both a medical model of controlling and hastening birth, as well as a supportive, nurturing and empowering model'* (p. 38). This paradox was expressed by the apparently oppositional concepts of *'following the mother's body'* and *'hastening and controlling labour'*. Sleutel notes that this led to practitioners using interventions they did not really support in order to avoid the (to the practitioners) larger risk of caesarean section for women who would otherwise have transgressed rigid technocratic labour norms. A similar practice was noted in Annandale's study of a birth centre (Annendale 1988), and it is the term Annandale coined to describe this situation that we have used here, namely *'ironic intervention'*. The risk here is the disruption of the virtuous circle of trust and belief, which we discussed above, and a downward spiralling of the potential for physiological birth and, indeed, for safe motherhood. Similar observations are hinted at in other papers in the review, although they are not expressed as fully there (Berg & Dahlberg 2001, James *et al.* 2003).

Discussion

Limitations

Although we identified many hundreds of papers that addressed expertise on the basis of opinion, and many quantitative papers assessing specific aspects of maternity care delivery, we found very few that fulfilled our search criteria of being good quality qualitative research studies. We are confident that our extensive search strategy and our reading of all the titles generated limited the risk that we have missed any significant English language research studies in this area. However, we may have missed relevant studies published in other languages. We acknowledge that our data set was limited: three of the papers were by the same author (Kennedy 2000, Kennedy 2002, Kennedy *et al.* 2004) two others had the same co-author (Berg & Dahlberg 2001, Lundgren & Dahlberg 2002), and only two countries are represented (USA and Sweden). We have noted that disparate criteria for 'expertise' were used, and that they included both those with and without formal midwifery qualifications. Following the critique of Nelson and McGillion (2004) we recognize the risk of reification, or of circular reasoning. Practitioners are likely to label as 'expert' those practices that they value, or that they feel may benefit them if they are valued by others external to their group. We could have looked to other judges, such as labouring women themselves, or obstetricians, or hospital managers, or government health

officials. However, each of these groups would also have only given a partial and particular view on maternity care expertise. The exclusion of quantitative studies may have limited the scope of our work, as there were far more of these studies in the general area of maternity care provision than there were of qualitative studies. However, we believe the view we present stands on its merits as our particular construct of the rich and in-depth accounts of a particular set of practitioners working in the field of intrapartum maternity care who are practising in ways deemed 'expert, exemplary, excellent, or experienced'. Our interpretation of the data may or may not have resonance for others in the field of maternity care, or for healthcare practitioners working in other fields.

Implications of findings

The findings of this review suggest that the overlapping concepts of wisdom, skilled practice and enacted vocation may offer a basis for a theory of expert intrapartum non-physician maternity care. We did not note any large variations between professional groups, although this topic remains to be fully explored in future primary research. Our interpretation has some resonance with the attributes of a 'good' midwife described by Nicholls and Webb (2006). Tangentially, our study also raises the question of how experts manage dissonance between disparate philosophies of care. Practitioners working in the intrapartum setting in many countries are being accommodated, willingly or unwillingly, into technocratic, industrialized models of care in the name of safety (Crabtree 2004, Mead 2004, El-Nemer *et al.* 2005). These models of care are based on assumptions that birth is inherently pathological, and that rule-based management can minimize the risks. They are somewhat at odds with the domains of expertise identified in this study, which are more aligned with a skilled and flexible response to complex and uncertain circumstances. In the Egyptian context, we have termed this 'skilled help from the heart' (El-Nemer *et al.* 2005).

Our findings have significant resonance with the work of Benner. Her more recent publications have built on her 'novice to expert' taxonomy, incorporating aspects of reflection-in-action, of caring, and of ethical and moral practice in the context of complexity (Benner *et al.* 1996, Benner *et al.* 1999). For us, this conception of the expert may be a consequence of wisdom, skilled practice and enacted vocation. From a feminist science perspective, such an expertise requires the exercise of 'hand, brain and heart' (Rose 1983). From a practical perspective, it requires the ability to minimize harm and maximize wellbeing at the complex level of the individual, within systems that demand rule-based

What is already known about this topic

- Nursing and medical expertise has been widely debated and researched, but the nature of non-medical maternity care expertise has not been systematically examined.
- A wide variety of practitioners provide intrapartum maternity care.
- Opinions about maternity care expertise are influenced by debates on safe motherhood on the one hand, and on the need to minimize unnecessary routine intrapartum interventions on the other.

What this paper adds

- Although there is a large opinion- and theory-based literature on non-medical intrapartum expertise, only seven qualitative research studies in this area have been published in English between 1970 and June 2006.
- A synthesis of the findings of these studies resulted in the identification of three domains of non-medical intrapartum expertise: wisdom, skilled practice and enacted vocation.
- Systems of maternity care that are designed to accommodate these domains in maternity care experts may optimize childbirth outcomes for women and babies.

responses to minimize risk at the population level. Davis-Floyd and Davis offer some possible examples of this in their exploration of 'postmodern' midwifery (Davis-Floyd & Davis 1997), and Lane proposes 'hybrid midwifery' (Lane 2002). However, evidence from studies of why midwives leave the profession, such as that undertaken in the UK by Ball *et al.* (2002), suggests that the currently predominant technocratic system of intrapartum maternity care does not permit a significant minority of practitioners to exercise their expertise. If this is replicated in other settings, there are implications for safe motherhood initiatives in countries where there are severe shortages of trained maternity care practitioners (World Health Organisation 2006), and for jurisdictions with excessively high rates of unnecessary intervention.

Conclusion

In the literature included in this review, intrapartum practitioners who are termed 'expert', 'exemplary', 'excellent' or 'experienced' demonstrated specific skills, attitudes, or characteristics that have not previously been identified together. Maternity systems that limit the capacity of expert practi-

tioners to perform within the domains identified may not deliver optimal care. If further empirical studies verify that the identified domains are essential for effective expert intrapartum maternity care, education and care delivery systems will need to be designed to allow practitioners to develop and express them.

Author contributions

SD was responsible for the study conception and design. SD, LS and KT were responsible for the drafting of the manuscript. LS and KT performed the data collection. SD, LS and KT performed the data analysis. LS obtained funding and SD supervised the study.

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Appendix Two

Group interview guide.

Welcome participants to group. Remind about tape recording and assuring confidentiality.

Concept: Expertise

Question 1. What qualities do you think expert midwives' have?

Prompts: What about expertise in the area of normality?

And in the area of pathology?

And in other areas (please specify)?

Concept: Normal birth

Question 2: What does the term normal birth mean to you?

Prompts: Is normal birth important? Why? Why not?

What midwifery practices and treatments are acceptable / not acceptable within the boundaries of normal birth? Why?

What medical or anaesthetic activities and treatments are acceptable / not acceptable within the boundaries of normal birth? Why?

What do you think women understand by the term normal birth?

Concept: Facilitating normal birth

Question 3. How do midwives' facilitate normal birth?

Prompts: Do different ways of organising staff make a difference? How? why?

Does the place of birth make a difference? How, why?

Do midwifery or medical practices make a difference? How, why?

Do the beliefs and philosophies of the attending professionals make a difference? How, why?

What about the beliefs and philosophies of the woman, her partner, her family?

Question 4 What do you think are the qualities of an expert midwife in the area of normal birth?

This question is a bit more focused than question 1. Please answer this question by thinking about someone you think is an expert in this area, and telling us what is particular about them (without naming them or identifying them to the group).

Prompt: Demographics *(age, years qualified years experienced for example)*
                Personality
                Skills or Beliefs

Appendix Three
Individual interview guide

Aims: To explore the inner meaning attributed to expert intrapartum midwifery practice.

1. I want you to think of someone who you regard an expert in intrapartum care

Tell me about your encounters with that person (or a specific encounter that best demonstrates his/her expertise)

Prompts: Tell me about some experiences that you may have had working with him/her
What is she like as a person?
What is it that makes her different from other midwives'?
What do women think of her?

Prompts: What do you think her midwifery philosophy is?
How does she view / use technology

Look for issues surrounding:
      Intuition
      Courage
      Leadership
      Knowledge / Education
      Skills
      Judgement

If not spontaneously explored by participants ask

2. How does he/she facilitate or promote normal birth? Can you tell me about any experiences you may have had

3. Have you worked with him/her in high risk or emergency situations? Can you tell me about that experience?

Appendix Four

Analytical process
Example of transcript analysis

320 You know that intuition. Erm, (names expert on labour ward), I've not come across
321 an emergency situation where I've seen her doing anything.

322   experienced   intrapartum expert.
                                   in charge   length of experien
                                                                    / Seniciviry
323 On the labour ward there's experts in 'THE LABOUR WARD'. You know, some of
324 the senior midwives' on there, who run there. I find are brilliant with normality. One   —experts in
325 of the midwives' (names expert) she's really good. If say, you are struggling and its   facilitating
326 been over two hours of pushing whatever, she can come in and she'll try with her   normality.
327 fingers to rotate the head to bring the head down. She's worked there thirty odd
328 years, you know her skill is just, she's very calm, again, calm. And but then she   \ calm + confiden co.
329 knows if its not going to come out. She'll know when to get the doctor. And in   limitations, awave
330 emergency situations, she absolutely brilliant. She knows exactly what to do. (pause) of when or rea
331 Itavic interventions.' interventions to reduce risk of instrumental delivry. \ own practice.
                                                                                        adaptable + skilled.
332 Do you think, I mean when people have explained to me the characteristics of an
333 expert, people have mentioned that normality, that is their niche (Yeah) one or the
334 other, Do you think that people can be experts in (yeah, yeah) high tech or high risk

335 interventions
                        / Promoting + facilitating normality.
336 No she's also an expert in normality. Because she's saved if you like, a lot of women
337 from having a caesarean. By doing, you know, I don't know how she does it. She   Facilitating
338 tries to turn the head herself. And she gets babies out, or (pause) women in positions / normal
339 that helps to get the baby out. So she does deal with well with normality, but also the   birth.
340 other side. I do feel that you can be skilful in both. Definitely. Because she really is.   Same
341 Whereas some of the other midwives' who are there all the time still adhere strictly to — Experts in
342 the policies. Whereas after two hours if a baby is not born, they'll probably call a   both high + low
343 doctor. Whereas for instance (names expert) would go in a try and bring the head   risk (inters exp
344 down, or whatever the situation is.
345 dont strictly adhere to policies - courageous).

346 Erm, I had a woman the other day who came in to be induced, and erm, she was like
347 "why is she being induced?" and I was looking through the notes and she said "but
348 she's not even 37 weeks. She's only 36 weeks. I'm not going to do an ARM on a
349 woman who's just, you know, 36 weeks. What other problems are going to happen,
350 you know if the cervix is thick, and long. Why didn't they do a, erm some prostin, or
351 leaving her until she's a bit further on." So she then range the doctor, and she said oh
352 you are right, somebody else had put that she was over 37 weeks. So she ended up
353 going home and coming back. She ended up still being induced, but it was a little bit
354 further along. Which might have been a bit helpful. So its definitely being for the - Confidence/
355 woman isn't it. You know, being autonomous, and for that woman, as well, being a   courage,
356 speaker for her. Because she has seen what can go wrong, and she tries to avoid it.
357 It's a really good thing.   \ knowledge + experience.

358

359 You mentioned before about the ways she promoted normality, you know things like
360 rotating the head, that's very interesting. Is there anything else that you can think of
361 that experts do to promote normality?

362   Antenatal preparation. Building womens
                                                /   knowledge + confidence.
363 Erm, hopefully it will be by giving the woman a lot of information. By discussing
364 what's normal and how to keep fit and healthy. And so that's the way that we can

Appendix Five

Study protocol

Title: **'Experts in the normal': an exploration of midwives' accounts of expertise in the context of normal childbearing.**

ABSTRACT OF RESEARCH

Background:

Worldwide reports of accelerating use of pharmacological and technical interventions in labour are giving rise to concern, not least on grounds of public health. This has relevance to recent UK policy documents, such as the Children's National Service Framework[1], and to RCM initiatives such as the Virtual Institute for Birth[2]. An examination of the nature of normal birth, and the factors which make up expertise in this area could be one of the routes whereby current trends are reversed. While there is a large body of research examining pathologies of childbirth, a systematic review undertaken by this team indicates that there appears to be only one small published North American study addressing midwifery expertise in normality [3]. The study proposed for this bid is a continuation of the work we have commenced in this area, as a part of a wider series of planned work in this area.

Objectives:

- To explore the range of midwives views and experience of midwifery expertise in general and in normal childbirth in particular.
- To generate a semi-structured questionnaire based on the findings of this study and the prior systematic reviews for distribution to midwives in subsequent studies in this area
- To generate hypotheses for further research in this area.

Participants:

A random sample of practicing midwives employed in a two consultant obstetric units and two midwifery led units located in the North-West of England.

Methods

Focus groups: As there is no current evidence exploring the subject, group dynamics would allow a wide exploration of knowledge, attitudes and experience.
This would aid in the development of a structured questionnaire, which will be used in further research.

Analysis

Analysis will be by open coding, and simple thematic synthesis

Proposed Duration	**Total Funds Required**	**Proposed Starting Date**
6 MONTHS	£11,758.40*	5th January 2004

* Travel costs to be confirmed when sites agreed

Summary of funds requested

Funds are requested for salaries for two research midwives to undertake the data collection and analysis. This is based on both researchers undertaking the study 16 hours per week, over a period of 6 months. £375 is sought for transcription costs. This is calculated on the basis that each focus group will take on average 1.5 hours, and that each hour of data requires 6 hours of transcription. All other costs, including consumables such as phone bills, postage, stationary, and travel, will be calculated after sites have been agreed. £1000 is sought for supervision time from UCLan.

Salaries: **Based on current salaries** Louise Simpson (Researcher 1) Katriona Trafford (Researcher 2)	£4189.44 £4800.00
Superannuation Louise Simpson (Researcher 1) Katriona Trafford (Researcher 2)	£251.36 £288.00
National Insurance Louise Simpson (Researcher 1) Katriona Trafford (Researcher 2)	£393.80 £460.80
Transcription	£375.00
Consumables (phone bills, postage, stationary, travel) N.B Includes travel to 4 research sites to undertake focus groups	To be negotiated
Research Supervision Soo Downe 4 days	£1000.00
Total Funds Requested	**£11,758.40**

Division of Responsibilities:

Louise Simpson will take the lead in
- Setting up the project, and gaining ethical approval.
- Creating and testing questionnaire
- Write up and publication

Recruitment of sites and participants, undertaking the focus groups, and data analysis will be conducted by both researchers.

Soo Downe will supervise the research study.

PROPOSED INVESTIGATION

Aim

To provide new understandings of normal childbirth and of midwives expertise in this area, to increase knowledge about techniques and approaches to promote normal birth within the midwifery profession, and to contribute to the debate about ways in which the use of technical and pharmacological intervention in childbirth may be reduced.

Background:

It is not uncommon for midwives to pronounce themselves 'the experts in normal childbirth'. This pronouncement goes largely unchallenged and is seen as a matter of some pride - even as a fundamental statement of identity. In using it, it is assumed that the terms 'expertise' and `normality' do not need explanation[4][5]. In depth analyses of the practice and impacts of midwifery do appear to indicate that, where midwives are indeed autonomous, the use of unnecessary interventions are minimised, and general well-being of mothers and babies is improved[6][7][8]. However, with the exception of a few authors[9][10] there is very little literature exploring the concepts, nature and boundaries of professional expertise in general, or of normal birth in particular.

It may be that the apparent failure to understand 'normality' has contributed to the current situation in childbirth, which has become increasingly influenced by a technocratic approach, where pharmacological and technical intervention are the norm in most western countries[11][12]. It could be argued that this is unimportant, if the reports of accelerating rates of use of pharmacological or technical interventions in labour in the UK[13][14] and, indeed most parts of the world, do not give rise to concern. However, it is becoming increasingly evident in the growing number of publications, which critique this phenomenon that the loss of so-called 'normal' labour and birth is seen by many professionals, policy makers and service users to be problematic[15][16][17]. Indeed, recent evidence suggests that the loss of trained midwives from practice in the UK may be partly explained by midwives perceptions that they are unable to practice as experts in normality in current labour ward environments[18]. Crucially, there is evidence to suggest that many routine interventions are unnecessary[19]; that interventions such as epidural analgesia tend to lead to other interventions for some women[20], with increased risk of long-term morbidity in some cases[21].

Understanding the nature of normal birth and the factors which make up expertise in this area, could be one of the routes whereby this trend is reversed. A number of studies have been undertaken of labour environments [22], [23], [24], and a few have also addressed midwives views of the nature of midwifery in general [25]. There appear to be only two small published studies which directly address midwifery expertise in normality, and both are set in a North American context [xi][26]. The study set out in this proposal is the second phase of a series of studies which are intended to provide new understandings of normal childbirth and midwives expertise, as an important

3

contribution to the emerging debate in this area nationally and internationally, and to political and governmental developments in the maternity services.

Objectives:

- To explore the range of midwives views and experience of midwifery expertise in general and in normal childbirth in particular.
- To generate a semi-structured questionnaire based on the findings of this study and the prior systematic reviews for distribution to midwives in subsequent studies in this area
- To generate hypotheses for further research in this area.

Participants

A random sample of practicing midwives based in the North West of England and employed in two consultant obstetric units, and all and two midwifery led units. One consultant unit will have higher than the UK average rates of normal birth (as defined by BirthChoice UK[27]) and the other will have lower rates of normal birth than the UK average, using this definition. One MLU will be free-standing, and the other will be an alongside unit.

Methods and analysis

This phase of the series of studies we are planning in this area is designed to elicit initial perceptions of normality, and of expertise, from practising midwives. The rationale for the nature of sites which we have specified is that they can be expected to cover a range of philosophical approaches to childbirth. Within the consultant units, the full range of grades of midwives will be employed. In each of these sites two focus group will be run (total 4 groups in consultant units), to minimise the impact of hierarchy on the participants contributions. One group will consist of E and F Grade midwives, and the other G and H grades. Following approval by the Head of Midwifery and the ethics committees in each Trust, the Head of Midwifery will be asked to select 10 possible participants for each group from a list of midwives in the Trust, using a random number table which we will provide. The Head of Midwifery will then send a letter of invitation prepared by us to these midwives. If the midwives agree to participate they will contact us direct to arrange the date, time and venue of each group.

The participating MLU's will be chosen at random from all the eligible MLUs in the geographical area of the study. In this case, it is likely that there will be minimal grade mix differentials, and the number of staff small. Therefore only one focus group containing 10 midwives will be conducted in each site. Midwives will be recruited using the same process of first contact from the local manager as described above. One focus group will be run in each MLU site.

The total number of groups to be run is therefore 6. If the data arising from the groups suggest that one to one interviews need to be conducted the feasibility of this will be considered, and built in to the project where possible. The information sheets and consent forms will include information about and consent for tape-recording of the group meeting.

One clinical midwife researcher will conduct the focus group, and the other will take field notes. The interview schedule for the focus group will be based on the findings of the reviews we have previously undertaken, and loosely structured to ensure that minimum direction is given to the debate, although significant key themes arising from the literature will be included. Once formulated, the interview schedule will be submitted to the relevant ethics committees for approval prior to its use. The topics of both normal birth and midwifery expertise in normality will be discussed.

Analysis will be by simple coding, and thematic synthesis. The initial transcripts will be analysed blind by at least two members of the research team, and agreement on the synthesis will be reached by consensus among the team as a whole.

If the data arising from the groups suggests that one to one interviews need to be conducted the feasibility of this will be considered, and built into the project where possible. All focus group participants will be sent a letter highlighting the main themes arising from the focus group data, to check their level of agreement. If at this stage it is decided that one to one interviews are required, participants will be sent a letter inviting them to take part in individual interviews. A consent form will also be provided. It is anticipated that interviews will be based on some of the outstanding issues from the summary of the focus groups. Participants will be given the opportunity to raise any additional matters that may not have been identified. Interviews will be tape recorded and transcribed verbatim. Additional consent will be requested for the video recording of interviews to allow in-depth exploration of non-verbal communication.

Following the analysis of the focus group data, and building on the findings from the systematic review, a questionnaire will be developed for wider circulation to midwives on the topic of the nature of and midwives expertise in normal birth.
The administration of the questionnaire will be subject to further protocol development and to funding from other sources, but its creation and initial testing will be an output from this project.

Benefits of the research

In the light of the background set out above, it is apparent that midwives accross the world are becoming aware that their role as the guardians of normal birth is being severely eroded. This is exacerbated by the lack of understanding of the skills and expertise midwives can and do have in this context. We believe that this work will be of benefit to midwives and to midwifery as a pivotal part of a larger series of studies designed to provide definitive answers in this area. This particular study will yield crucial data in this area its own right, as well as adding to the value of the whole project. We believe it will provide data, which will inform policy and practice, national governmental agendas, and international thinking in this area.

In the longer term we hope that this research and the project it forms a part of will influence midwifery practice, and thus the current way we do birth, with the ultimate and fundamental aim of improving birth for women, babies, families and societies.

Ethical considerations

The research will not start until LREC ethics committee approval has been obtained from all relevant committees. All participants will initially be contacted by a manger who has ethical access to their details. They will all be informed that confidentiality will be guaranteed, and no one will have access to the original questionnaires other than the research team. Transcripts and databases will be coded to the questionnaires, and no other identifiers will be used. Data, including tape recordings from the focus groups and coding sheets, will be stored and destroyed in accordance with the requirements of the LRECs, the Data Protection Act, and local Caldicott requirements.

Project Management

This project will be managed by a project steering group, comprising all the collaborators on this bid, the research staff, representatives from the involved Trusts, service users, and, if required, from the funders. This group will meet face to face once at the beginning and once in the fifth month of the project. Other contact will be by email.

Framework for support for research

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                          │     L.R.E.C      │
                          └─────────────────┘
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│ University of Central    │ │ East Lancashire     │ │ Selected Trusts for  │
│ Lancashire               │ │ NHS Trust           │ │ study to be undertaken│
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│ Principal Research   │  │ Trust Research│ │Applicant(s)│ Selected liaison     │
│ Lecturer             │  │ and Development│ │managers  │ │ person(s) or research│
│ Dr. S. Downe         │  │ Department    │ │          │ │ midwives.            │
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                          ┌──────────────┐
                          │Research Midwife│
                          │Cathie Melvin  │
                          └──────────────┘

                   ┌──────────────┬──────────────┐
                   │ Applicant 1  │ Applicant 2  │
                   │Louise Simpson│Katriona Trafford│
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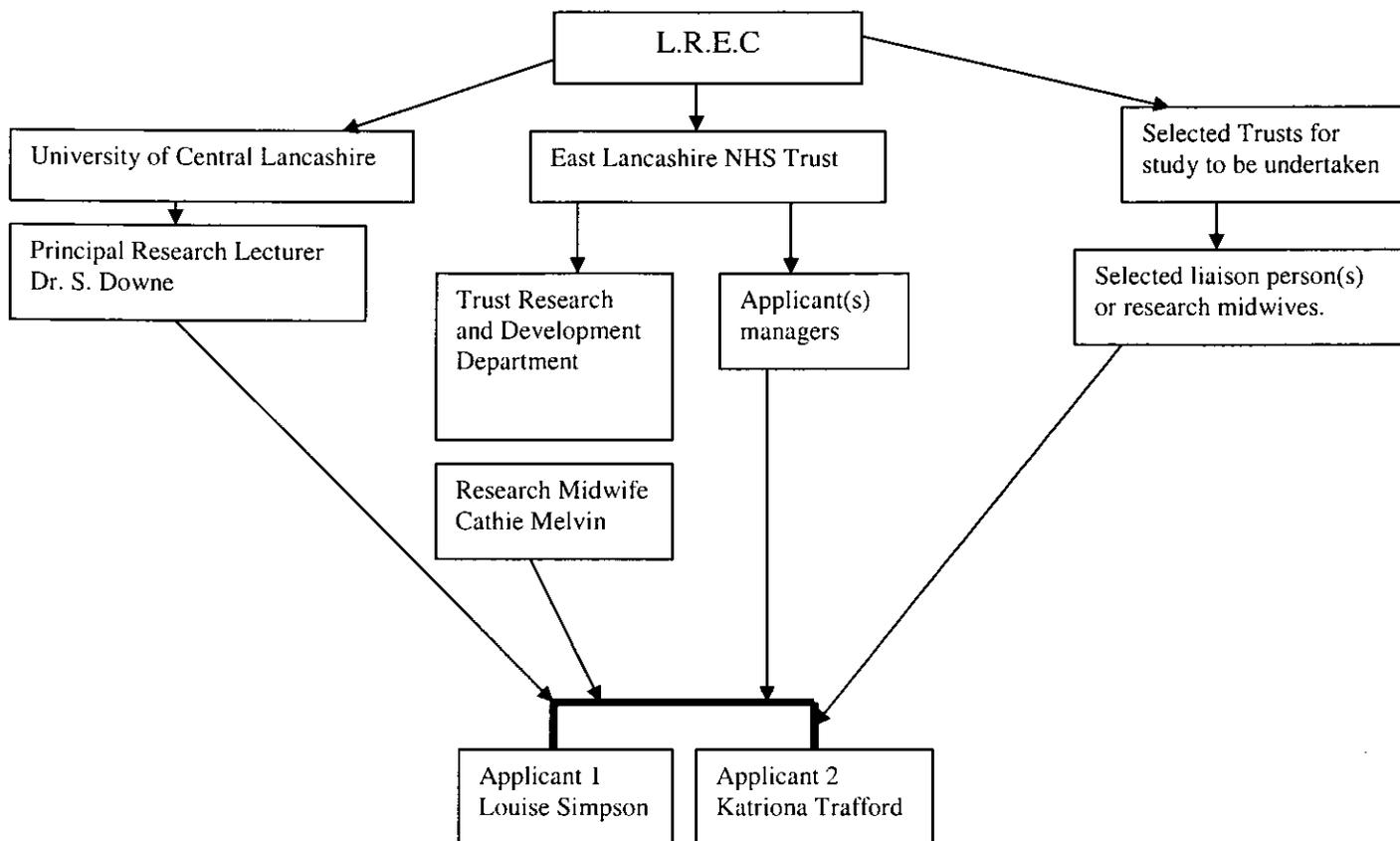
There will be a meeting with Louise, Katriona and Soo scheduled for at least once a month during the project. Informal contact with Soo, Cathie Melvin and Catherine Gedling will be available throughout the project. The Trust has agreed to release Louise and Katriona to do the work if this bid is successful.

Results and Dissemination

Dissemination will be by a publicly available report, submissions for publication to peer reviewed journals, and submission to peer reviewed and service user conferences.

Future Work

There is national and international interest in promoting normalisation in pregnancy and childbirth. This study is planned as the second in a programme of work on this topic. Further, probably external, funding will be sought for the later stages of the work, including the administration and analysis of the questionnaire.

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Appendix Six
Participant information sheet

'EXPERTS IN THE NORMAL': AN EXPLORATION OF MIDWIVES' ACCOUNTS OF EXPERTISE IN THE CONTEXT OF NORMAL CHILDBEARING.

Participant information sheet. Follow up individual interview

You are being invited to take part in a follow up interview arising from the original focus group research study you previously participated in. Before you decide whether to take part it is important for you to fully understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Background

The reports of rising rates of use of pharmacological or technical interventions in labour give rise to concern. Understanding the nature of normal birth and the factors which make up expertise in this area, could be one of the routes whereby this trend is reversed.

What is the purpose of this study?

To establish midwives views of the nature of normal birth and midwifery expertise in normal childbirth.

How will this part of the study be conducted?

Midwives who took part in the previous focus groups will be invited to take part in one individual interview to explore some of the themes further. This will add greater depth to the research findings, and also allow individual perspective to be explored. We are hoping to conduct 5 individual interviews at this stage of the project. Therefore the first five midwives returning consent forms will be included in this part of the project. Additional midwives who agree to take part will be contacted, and the feasibility of conducting additional interviews will be considered.

Do I have to take part?

It is up to you whether or not you take part. If you decide to take part you will be given this information sheet to keep and you will be asked to sign the consent form in this pack.

If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect working relationships within the trust.

What will happen to me if I take part?

When you have returned the consent form, one of the researchers will contact you by telephone to arrange a date for the Individual interview. The interview will be conducted at a time and location specified by yourself. It will last approximately one hour.

The interviews will be based on some of the outstanding issues from the summary of the focus groups, but you will also be given the opportunity to raise any matters that have not come up so far.

The discussion will be tape-recorded (or video-recorded if you consent to this), with field notes taken by the researcher. You can request that the tape be stopped, replayed and edited at any time. No names will be used when the interview data is transcribed. Confidentiality will be assured. Data, including tape recordings from the interview, will be stored and destroyed in accordance with the requirements of the COREC, the Data Protection Act, and local Caldicott requirements.

What are the possible problems or risks of taking part?

As we are asking you about thoughts, feelings and expectations, there are no physical risks. However, talking about difficult experiences may be upsetting for some midwives. If this happens, or if you have any other major problems, which you want to share during the research, the researcher will be able to refer you to the appropriate people if you want her to. You can use the contact number or e-mail on this sheet to contact the researchers about this or any other matter related to this study.

What if something goes wrong?

If taking part in this research harms you, there are no special compensation arrangements. If you are harmed by someone's negligence, then you may have the grounds form legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you. In the event of a complaint, please contact
C. Melvin, Research Midwife, Royal Blackburn Hospital, Blackburn. 01254 293944.

Will taking part in this study be kept confidential?

All information that is collected during the course of this research will be kept strictly confidential. All information will have your name removed so that you cannot be recognised from it. Tape-recorded information will be transcribed without using names, the tapes will be stored in a secure place, and deleted once they have been transcribed.

In the extremely unlikely event that any dangerous practise issues be disclosed during the focus group discussion, the researcher will discuss this individually with the participant concerned and refer to the supervisor of midwives if necessary.

What will happen to the results of the research study?

The results will be submitted for publication to leading midwifery and obstetric journals, and will be presented at local, national and international conferences.

Who is organising and funding the research?

Mrs Louise Simpson, Midwife, East Lancashire NHS Trust (Lead researcher for the project)

Mrs Katriona Trafford, Midwife, East Lancashire NHS Trust (Researcher for the project)

Professor S. Downe, Department of Midwifery studies, University of Central Lancashire.

Who has reviewed this study?

The research to be carried out has been approved by the Local Research Ethics Committee appointed by the Health Authority. This does not imply any endorsement.

This study has been reviewed by:
The Local East Lancashire NHS Trust Research Ethics Committee.
UCLAN midwifery Studies Research Unit Scientific Committee.

What do I do now?

If you are still happy to take part, please complete the consent form at the end of this information sheet, and return them in the envelope provided. You will be contacted by the researcher to arrange the data and time of your interview.

If you do not return the consent form within 7 days we will assume you do not wish to participate.

Contact for further information:

Mrs Louise Simpson
C/o Ward C9, Royal Blackburn Hospital
Haslingden Road, Blackburn
Lancashire
BB2 3HH
Telephone 01254 293940 (work)
Telephone 07941 640432 (mobile)
E-mail lousimpson@tiscali.co.uk

Thank you for taking the time to read this information.

PARTICIPANT CONTACT SHEET:

Please provide the following contact details if you wish to take part in the follow up interview. **PLEASE RETURN IT WITH YOUR CONSENT FORM.**

NAME:

PLACE OF WORK:

TELEPHONE CONTACT NUMBER (please indicate whether this is work or home)

PREFERRED METHOD OF CONTACT (IE EMAIL / PHONE / ADDRESS)

Thank you

'EXPERTS IN THE NORMAL':
AN EXPLORATION OF MIDWIVES' ACCOUNTS OF EXPERTISE
IN THE CONTEXT OF NORMAL CHILDBEARING.

Participant consent form
(Version 1.0 June 2006)

Participant identification number _____

Name of Researcher(s)   Mrs Louise Simpson

( )   **I have read and understand the information sheet dated June 2006 (version 1.0) for the above study and have been able to ask questions.**

( )   **I understand that taking part is up to me and that I can leave the study at any time, without giving any reason.**

( )   **I agree to take part in the above study**

( )   **I agree to the tape recording of the interview**

( )   **I AGREE / DO NOT AGREE (delete as appropriate) to the video recording of the interview (THIS IS OPTIONAL)**

_____   _____   _____

Name of Participant   Signature   Date

'EXPERTS IN THE NORMAL':
AN EXPLORATION OF MIDWIVES' ACCOUNTS OF EXPERTISE
IN THE CONTEXT OF NORMAL CHILDBEARING.

Participant consent form
(Version 1.0 June 2006)

Participant identification number _____

Name of Researcher(s)   Mrs Louise Simpson

( )   **I have read and understand the information sheet dated June 2006 (version 1.0) for the above study and have been able to ask questions.**

( )   **I understand that taking part is up to me and that I can leave the study at any time, without giving any reason.**

( )   **I agree to take part in the above study**

( )   **I agree to the tape recording of the interview**

( )   **I AGREE / DO NOT AGREE (delete as appropriate) to the video recording of the interview (THIS IS OPTIONAL)**

_____   _____   _____

Name of Participant   Signature   Date