**School of Nursing, Midwifery and Paramedicine**

# Western Australian Midwives' Perceptions and Experiences of Being 'With Woman' During Labour and Birth

**Zoe Bradfield**

**This thesis is presented for the Degree of**

**Doctor of Philosophy**

**of**

**Curtin University**

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# Declaration of Originality

**Declaration**

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

**Human Ethics**

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number (HREC 2016 - 0450).

Zoe Bradfield

07. 03. 2019

Date

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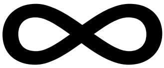

# Publications, Presentations and Awards

| Publications |
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| Bradfield, Z.  (2017). Being 'with woman' by working in partnership with women. Australian Midwifery News. Vol. 17, No. 4 |
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| Walking a Path Together: Midwives' Experiences of being 'with woman' in a Continuity Model. Mark Liveris Seminar, Curtin University, September 2018 |
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| Awards |
| 2018 Mark Liveris Research Student Seminar, Curtin University, First Prize, Best Paper Presentation Award |
| 2016 Advancing the Midwifery Profession Fellowship, Merit Selected, WA Department of Health, $20,000 |
| 2016 Curtin University Postgraduate Scholarship, PhD Research, Merit Selected, 3 years |
| 2016 Australian Postgraduate Award Scholarship, PhD Research, Merit Selected, 3 years |
| Conference Abstracts (submitted and currently under review) |
| *Local Perspectives on a Global Phenomenon: Midwives 'With Woman'*. International Confederation of Midwives Conference, Bali Indonesia, 2020 |
| *The Power of Identity: Midwives' Perceptions of Being 'With Woman'*. Australian College of Midwives Conference, Canberra, Australian Capital Territory, September 2019 |
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# Co- Author Contributions

The following author contributions are a requirement for presentation of a thesis containing publications arriving from doctoral research at Curtin University. An adaptation of The International Committee of Medical Journal Editors (ICMJE) guidelines for authorship are presented below for each published manuscript contained within this thesis. A rating of 0 – 3 + symbols is given to differentiate levels of contribution from each co-author, with 3+ being the highest contribution. The papers are presented here in order of their appearance in the manuscript.

**Paper 1. Integrative Review**

Bradfield, Z., Duggan, R., Hauck, Y., & Kelly, M. (2018). Midwives being 'with woman': An integrative review. *Women Birth, 31*(2), 143-152. http://dx.doi.org/10.1016/j.wombi.2017.07.011

| | Conception and design | Acquisition of data & method | Data conditioning & manipulation | Analysis & statistical method | Interpretation & discussion | Final Approval |
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# Abstract

Being 'with woman' is an important philosophical construct for the profession of midwifery, written into the professional statements of peak midwifery bodies around the world. Indeed the International Confederation of Midwives emphasises the importance of being 'with woman' by working in partnership with women and their families. The urgent call from midwifery leaders worldwide is issued in editorials, reference texts and periodical publications for midwives to be 'with woman' in their practice. The phrase to be 'with woman' is entrenched in the professional vernacular of midwives around the world.

Despite the centrality of being 'with woman' to the profession of midwifery, there is little empirical evidence to facilitate an evidence-based understanding of the phenomenon. There has been a reliance on an assumed common understanding of what it means for a midwife to be 'with woman' based largely on expert commentary. The importance of relationship between the midwife and the woman is an accepted feature of the phenomenon however there is little else known about how midwives themselves conceptualise and practise being 'with woman'.

The aim of this study was to explore Western Australian midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth. This overall aim was achieved through two discrete objectives, of which, the first was to understand midwives' perceptions of the phenomenon of being 'with woman', in order to gain an understanding of how midwives themselves conceptualise the phenomenon. The second, to explore the lived experiences of being 'with woman' during labour and birth from the perspectives of Western Australian midwives working in a range of practice contexts.

This qualitative study was conducted using a descriptive phenomenological design. The genesis of descriptive phenomenological research is found in the philosophy of phenomenology developed by Edmund Husserl. This philosophy permeates and guides each stage of the research design in the phenomenological method offered by Giorgi which is used in this study. One to one, in-depth interviews were conducted with 31 midwives currently providing intrapartum care to Western Australian women in a range of settings.

The midwives worked in one of the following three models which is representative of the Western Australian maternity setting; where care in labour is provided by 1) a known midwife in a continuity of care model; 2) an unknown midwife in the 'standard' public hospital care model; and 3) an unknown midwife and known obstetrician within the private obstetric model.

Data were collected concurrently from midwives working in each of the three models, with no predetermined agenda to join or separate the distinct groups. The rigorous structure of Giorgi's approach to data analysis facilitated clarity revealing how the phenomenon of being 'with woman' was both perceived and experienced by the midwives. In this way, it became apparent that being 'with woman' was perceived and conceptualised similarly by midwives working in all of the models. Also evident, was that the phenomenon was experienced differently by midwives working in each of the models, with unique intersecting factors inherent in each model. This guided the process of analysis where findings are presented with midwives' perceptions of being 'with woman' collectively, and midwives' experiences of the phenomenon presented separately according to the model worked in.

The findings of 31 midwives' perceptions of being 'with woman' noted that despite a variance in years of experience, method of midwifery education and model of care worked in, the phenomenon was perceived with a striking congruence. How midwives described what it means to be 'with woman' was remarkably similar despite the variation in the above mentioned factors. The 'essences' of their perceptions of being 'with woman' were captured in themes 1) essential to professional identity; 2) partnership with women; and 3) woman-centred practice.

Midwives (n=10) working in continuity models where labour and birth care is provided by a known midwife described their experiences of being 'with woman' in the context of the model which provides an opportunity to form a deep connection with the woman. The descriptions also revealed factors unique to the model which intersected with midwives' ability to be 'with woman', the essences in the context of this model were 1) building relationships; 2) woman-centred care; 3) impact on the midwife; 4) impacts on the woman; and 5) challenges in the known midwife model.

In the standard public hospital model where care is provided to labouring women by 'unknown' midwives (n=10), the findings described the importance of developing a rapid rapport with the woman and considered factors unique to the model which intersected with the phenomenon of being 'with woman'. The themes were 1) building a connection; 2) the influences of the unknown midwife model on being 'with woman'; and 3) the rewards and challenges of being 'with woman' within the UM model.

The final model in the Western Australian maternity system offers care during labour from unknown midwives but known obstetricians. A unique aspect of this model is reflected in the commercial agreement between the woman and her obstetrician. Midwives' (n=11) descriptions of being 'with woman' in this model centred around two main themes of 1) triad of relationships; 2) the intersection between being 'with woman' in the context of the private obstetric model.

Findings from this Western Australian study provides urgently needed evidence about the phenomenon of being 'with woman' which globally, is considered fundamental to the profession of midwifery. New findings make a substantial and innovative contribution to the body of knowledge about the philosophical construct of being 'with woman'. Importantly, hyletic descriptions provided by midwives reveal for the first time, the experience of being 'with woman' in a variety of settings which provides crucial sign posts in developing an understanding of the phenomenon but also how it is experienced in diverse clinical contexts.

The unique insights obtained from this research have implications for service managers, professional leaders, educators and midwives alike. Understanding how the phenomenon of being 'with woman', so central to the profession, is perceived by midwives themselves; and how their experiences intersect with the various models provides a new base of evidence from which to conduct further research.

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# Chapter One • Thesis Introduction

## Introduction

This first thesis chapter provides an introduction to this study. It offers an overview of the 'with woman' phenomenon and describes the context for this research which was undertaken in a variety of maternity settings in Western Australia. The author's interest in the field of midwifery philosophy is clarified and introduces the reader to the research problem which provides a focus for an extensive review of the literature. This study has been conducted using the research methodology of descriptive phenomenology, the rationale for which is described within the methodology chapter (Chapter 3). The aim and objectives of the research are identified within the context of the phenomenological approach. The significance of this study is discussed and finally, an outline of this thesis is presented.

## Background literature

Being 'with woman' is a central construct of the profession of midwifery. Philosophy statements from peak midwifery bodies around the world reference the importance of midwives being 'with woman' and working in partnership with women and their families (ACM, 2004; ACNM, 2004; Guilliland, 2010; ICM, 2014; RCM, 2014). The Australian College of Midwives' professional philosophy statement is prefaced by the following sentence "Midwife means 'with woman': this underpins midwifery's philosophy, work and relationships" (ACM, 2004, p. 1). This preface indicates the centrality of the phenomenon of being 'with woman' and highlights its important role in underpinning midwifery practise. The Australian Professional Standards for Midwifery also emphasise the importance of being 'with woman' to the work of midwifery (NMBA, 2006a, 2008, 2018). So too, the International Confederation of Midwives' Philosophy and Models of Care Statement urges midwives to work in partnership with women in a way that is centred around the woman and her family (ICM, 2014).

The importance of integrating knowledge generated through expert commentary and philosophy, along with the skills specific to midwifery has been noted by several prominent midwifery leaders (Fahy, 1998; Leap, 2009; Page, 2003; Page, 2008). The importance of developing a partnership or professional relationship with the woman to the practise of being 'with woman' is a widely reported feature in professional, theoretical and editorial commentary (Crowther et al., 2016; Hunter, 2015; Kennedy, Anderson, & Leap, 2010; Leap & Hunter, 2016). These assertions by midwifery leaders have provided important knowledge that signposts the need for an evidence-informed understanding of how the midwife-woman relationship forms part of being 'with woman' in the various maternity contexts that midwives work.

Much of the current empirical understanding about being 'with woman' is derived from research that has explored women's experiences of what is considered to be exemplary midwifery care (Hunter, 2002; Hunter, 2009). Professional leaders have also asserted the importance of being 'with woman' in midwifery practice through professional and editorial commentary (Fahy, 1998; Kennedy et al., 2010; Leap & Hunter, 2016). It is noteworthy that both the research and professional commentary that currently exists principally references being 'with woman' in the context of labour and birth care (Hunter, 2002; Hunter, 2009; Leap & Hunter, 2016). This current evidence influenced the decision to explore the phenomenon further within the intrapartum context. Additionally, this stance would contribute and build midwifery knowledge by expanding our understanding of being 'with woman' through a phenomenological approach that considered the experience in a variety of maternity contexts.

In all of the professional writings, there was clear agreement that being 'with woman' was an important and central aspect of the profession of midwifery (ACM, 2004; Fahy, 1998; Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008; Hunter, 2015; Hunter, 2009; ICM, 2014; Leap & Hunter, 2016). There were however, few, fragmented descriptors of the phenomenon. One account was taken from hermeneutic analysis of poetry written by ten US based midwives and revealed that midwife poets saw their role as being partners in birth, developing spiritual connections and providing experienced guidance to women (Hunter, 2003). Another depiction, from a review of research that had sought to provide

guidance to the midwifery care of labouring women suggested that being 'with woman' "... provides psychological and physiological benefits for women, client satisfaction and potential cost savings "(Hunter, 2002, p. 1) .

These isolated statements facilitated the focus of the literature review (presented in Chapter 2) which was to uncover 'what is known about being 'with woman'? Further details are presented in the second chapter, as the use of an integrative review protocol provided a framework for both a broad and deep discovery of the current understanding of the phenomenon as expressed in published research and editorial or expert writings.

## The researcher's background and interest

As a midwife of 16 years, with experience in a variety of rural and metropolitan settings, the researcher's interest in the concept of being 'with woman' first came about during entry to midwifery education. Reference was made to the importance of being 'with woman' and ensuring that midwifery care was aligned with the woman's agenda; this concept formed a bedrock of identifying the fundamental constructs of what it means to be a midwife and provide midwifery care. Being 'with woman' was not explicitly described at this early stage of the educational journey, however the sense was that it involved the midwife putting the woman at the centre of her care and acting as her advocate. Despite the paucity of any formal description based upon evidence, this concept of being 'with woman' and providing care that was centred on the agenda of the childbearing woman guided the researcher's professional practise. After more than a decade of clinical practise, now as a midwifery educator in a tertiary setting, there was a keen sense of the imperative to ensure that graduates were prepared for midwifery practice with a sense of what is unique, identifying and distinctive about the profession of midwifery from other caring professions. Additionally, the researcher was inspired by global midwifery leaders who had issued a call to ensure that students graduated with an understanding of what is unique and identifying about the profession of midwifery.

A recognised place to start was to introduce students to the previously mentioned professional philosophy statement issued by the peak professional body for midwives in

Australia, the Australian College of Midwives (ACM). In considering the development of learning and teaching activities that might provide an applied understanding, the researcher started to explore the base of evidence that was anticipated to guide her understanding of the characteristics and manifestations of this most important phenomenon of being 'with woman'. Although frequently referenced in the professional vernacular, and with a plethora of midwifery expert and editorial publications imploring midwives to be 'with woman', it was surprising to discover that there had been no explicit research conducted to give an empirical understanding of the constructs of being 'with woman' from the perspective of midwives. This dearth of information was useful to define the research problem and influenced the framework for an integrative review of the concept of being 'with woman' which forms the basis of chapter two.

## Research Problem

The comprehensive literature review detailed in chapter 2 confirmed the importance of being 'with woman' to the profession of midwifery, and highlighted the knowledge gaps. The findings of the review, provoked the following questions thereby justifying the need for this research project:

- What are the essential and identifying features of the phenomenon?
- If being 'with woman' is so important to midwifery, how would a midwife confirm that they were 'doing' it?
- How does being 'with woman' manifest in the context of the different maternity settings that Western Australian midwives might work in?
- Within those settings, are there any factors that might influence midwives' ability to be 'with woman'?

These questions or research problems which align with the gap in current knowledge were useful to formulate the research aim and objectives for this study. Advised by the philosophy of Husserlian phenomenology, the phenomenological method seeks to uncover the necessary and invariant features of the phenomenon under study (Giorgi, 1997, 2009). The underpinning philosophy was useful for the development of the study aim and

objectives. The methodology and methods employed in this research are described in further detail in Chapter 3.

## Research Design, Aims and Objectives

A descriptive phenomenological design was chosen to address the overall aim and specific objectives. The aim of the study was to explore Western Australian (WA) midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth.

Two specific research objectives were derived from the aim that informed the selection of a phenomenological approach to the research:

1. To describe WA midwives' perceptions of the phenomenon of being 'with woman'.
2. To explore the lived experiences of being 'with woman' during labour and birth from the perspective of WA midwives working in a range of practice contexts.

## Context of the Study

Considering the asserted centrality of relationship, and connection with the woman, to the philosophy of being 'with woman'(ACM, 2004), as well as the identified gaps in knowledge, it is timely to explore the phenomenon and to consider the phenomenon as it is experienced within the various WA maternity contexts where midwifery care is provided by known or unknown midwives. In Australia, maternity care is provided in a two- tier system of public and private service models. In the state of Western Australia (WA), the setting of this study, women have a variety of choices available to them when selecting maternity care (see Table 1 – Models of care). Women may choose pregnancy and birth care in a public hospital; care through one of the publicly funded continuity of care programs with several options of where to birth; or may elect to employ a privately practicing midwife to attend their care and birth in a variety of settings. Finally, women who hold private health insurance may decide to receive care from a private obstetrician and birth within a private hospital (DOHWA, 2016).

In spite of the variety of maternity services and places of birth available in Western Australia, women will receive care during labour and birth by an:

1. Unknown midwife (UM) ; or an
2. Unknown midwife, but a known obstetrician (UMKO) ; or a
3. Known midwife (KM)

Table 1. Models of Midwifery Labour and Birth Care in Western Australia

| | **Unknown Midwife (UM)** | **Unknown Midwife Known Obstetrician (UMKO)** | **Known Midwife (KM)** | | |
|---|---|---|---|---|---|
| | Public Obstetric-led Midwifery Care | Private Obstetric-led Midwifery Care | Public Midwifery Group Practice (MGP) | Public Community Midwifery Program (CMP) | Privately Practicing Midwife (PPM) |
| | Woman attends hospital where labour care is usually[1] provided by an **unknown midwife** | Woman attends hospital where labour care is provided by an **unknown midwife** managed by the woman's **known obstetrician** | Woman contacts her **known midwife** and prepares for birth in planned place | Woman contacts her **known midwife** and prepares for birth in planned place | Woman contacts her **known midwife** and prepares for birth in planned place |
| **Woman's Planned Place of Birth** | | | | | |
| **Public Hospital** | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Private Hospital** | | ✓ | | | |
| **Public Birth Centre** | | | ✓ | ✓ | |
| **Planned Home Birth** | | | ✓ | ✓ | ✓ |
| **Freestanding Birth Centre** | | | ✓ | ✓ | ✓ |

1 In some smaller rural or secondary public hospitals, it is possible that the midwife may provide antenatal care and serendipitously provide labour and birth care and so there may be opportunity for relationship, it is estimated that this would account for <1% women in this model.

Summarised data from WA Department of Health 'Having a Baby' (DOHWA, 2016)

How these three models of midwifery care articulate into the various maternity settings in WA is summarised in Table 1. A known deficit in data reporting means that currently, there

is no reliable data that indicates the prevalence of models of maternity care provided in WA (AIHW, 2014, 2016). The data currently available reports on workforce within the public and private sectors (Health, 2017) as well as outcomes for mothers and babies reported by each sector (Jennings, Joyce, & Peirce, 2018). The most recent data available, indicates that in WA, 63% of midwives are employed in the public sector (Table 2). Whilst the majority of midwives in the public sector are employed in the 'standard' fragmented models (where care in labour is provided by an 'unknown' midwife [UM]), it is noted that publicly funded continuity models (where care in labour is provided by a 'known; midwife [KM]) are increasing in prevalence within WA confirmed in communication with the Western Australian Acting Principal Midwifery Advisor (Costins, 2019) and nationally, (Homer, 2016). At a national level, it is acknowledged that data that reports solely on models of funding (public/ private) or place of birth (hospital/ birth centre/ home) are insufficient and further detail on models of care is required. Plans are underway at a Federal government level, to report on prevalence and outcomes data for the various models of care in each jurisdiction (AIHW, 2016).

Table 2. Registered and Employed Midwives-Western Australia

| Employment sector | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| **Public sector only** | 1,595 | 1,603 | 1,582 | 1,582 |
| **Private sector only** | 710 | 727 | 720 | 742 |
| **Both** | 68 | 74 | 62 | 60 |
| **Non response** | 248 | 186 | 215 | 206 |
| **Total** | 2,621 | 2,590 | 2,579 | 2,590 |

Source: National Health Workforce Data Survey 2013-2016 **(DOH, 2017)**

**Midwives include Midwife only, RN & Midwife, EN & Midwife, RN & EN & Midwife**

**Note the sector splits are based on clinical midwifery hours in public and/or private**

In the private obstetric model, the most recent data from 2015 reported that over 40% of pregnant women in WA chose to receive maternity care under this model compared with a national average of 27% (AIHW, 2017). In this model, antenatal care is provided by the

chosen obstetrician and in some instances, in conjunction with midwives employed to work in the obstetrician's practice (DOHWA, 2016). A unique aspect to this model is that women rarely engage with midwives at the respective hospital until labour commences or is induced (DOHWA, 2017b). In the private obstetric model, midwives are employed by the private hospital and provide care to the woman under the direction of the chosen obstetrician who has been privately contracted by the woman. In this way, women receive care during their labour and birth by unknown midwives but known obstetricians (UMKO). The most recently available data shows that over 30% of midwives in WA are employed in the Private Obstetric model (Table 2 – Registered and Employed Midwives in WA).

## Significance of the study

The findings of this study provide new and important knowledge in describing the structures and constituents of the phenomenon of being 'with woman' which is asserted as being fundamental to the profession of midwifery. Revealing essences of the phenomenon so pivotal to the profession will provide evidence that is useful for the development and evaluation of midwifery practise. Capturing and presenting a contemporary perspective of the phenomenon using a scientific approach offers an opportunity to consider the canonical assertions made by midwifery leaders within the context of applied midwifery in a variety of settings. Gaining insight into midwives' perceptions of being 'with woman' provides the opportunity for future research into the exploration of the assimilation of professional philosophy into midwifery practise.

New knowledge derived from this research will be used to inform educational curricula for future midwives and may strengthen the understanding and implementation of 'with woman' midwifery care. This research project is a response to the call to include opportunities for the development of 'with woman' practices within curricula (Fahy, 1998; Hunter, 2015). Findings will provide an authentic insight into the constructs of this midwifery practise based in philosophical propositions which will enable teaching of future midwives to be conducted from knowledge based in evidence.

Understanding experiences of being 'with woman' and considering factors which might challenge and enable this practise will be useful for midwifery service managers and senior health leaders as they consider the development of future health services and improvement of current services. Having an applied understanding of the constituents of the phenomenon, will enable a broad perspective and facilitate health service design that is ideally aligned with the philosophy of the midwives providing the care across all maternity settings.

## Thesis Outline

This dissertation is organised into eight chapters. The following outline provides the framework and overarching perspective of the layout and content of each chapter. Four peer reviewed journal articles including an integrative review and the findings of this study have been published and a fifth is currently under review. Each chapter addressing the review of the literature and study findings presents the final proof-copy manuscripts in accordance with the copyright policy of each journal.

**Chapter Two** introduces the final accepted manuscript of the published integrative review that was conducted to advise the gaps in the research. An updated search of the literature since manuscript publication has been conducted and presented as a prologue.

**Chapter Three** commences with an appraisal of the various research paradigms and methodologies that were considered by the researcher. An introduction to the philosophical framework of phenomenology and the various fields of phenomenological research is presented. Rationale is given for the selection of descriptive phenomenology and the important characteristics of this research design and methods is presented. Finally, features of this research that enhance rigour are provided.

**Chapter Four** includes the manuscript which reports the findings of the research addressing the first research objective which describes midwives' perceptions of the phenomenon of being 'with woman'. The manuscript is currently under review.

**Chapter Five** presents the final accepted manuscript of the findings of the research that addresses the second research objective – exploring midwives' experiences of being 'with woman' during labour and birth in the context of the known midwife (KM) model.

**Chapter Six** is comprised of the final accepted manuscript that presents findings of the research addressing the second research objective – exploring midwives' experiences of being 'with woman' during labour and birth in the context of the unknown midwife (UM) model.

**Chapter Seven** includes the final accepted manuscript which presents findings of the research addressing the second research objective – exploring midwives' experiences of being 'with woman' during labour and birth in the context of the final, unknown midwife, known obstetrician (UMKO) model.

**Chapter Eight** provides a final summary of the findings against the aim and objectives of this study. A novel approach to presenting implications and recommendations is adopted. Strengths and limitations of this research are discussed which support a final conclusion to the thesis.

## Conclusion

This introductory chapter has described the focus of this study, providing an overview of the phenomenon of being 'with woman' as it is understood within the profession of midwifery. The context for this study based in Western Australia has been explained as well as introducing the reader to the author's interest in conducting the research. The research problem has been identified which provided an emphasis for a subsequent review of the literature covered in the next chapter as well guiding the aim and objectives of this study. The anticipated significance of the research has been discussed and a final outline of the thesis has been presented. Chapter two presents an exploration and critique of the literature from both empirical and midwifery expert sources in the form of a published integrative review. The literature review identifies both what is known as well as the gaps that exist which serves to justify the need for the study.

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# Chapter Two • Literature Review

## Chapter Introduction

This chapter contains the final manuscript of an integrative review which was published in Women and Birth Journal (Bradfield, Duggan, Hauck, & Kelly, 2018). The findings of the review revealed that the current knowledge concerning the phenomenon of being 'with woman' is primarily derived from expert commentary from global midwifery leaders and research that explores women's experiences of what they perceived to be exemplary midwifery care. There is evidence that the philosophical and theoretical assumptions of being 'with woman' are well embedded and accepted within the midwifery profession throughout the developed world, however there is a gap in understanding how being 'with woman' is understood or experienced by midwives.

Since the publication of this review, further consideration of this article has been given by the authorship team who believe that there are additional clarifications that would support this manuscript. An inclusion criteria that was applied (and implied) but not referenced was that only papers published in the English language were selected. This extends to references within the discussion section that report how embedded the phenomenon of being WW is within the midwifery profession across the developed world. The understanding and assertion is made based on English publications and refers to the Anglophone developed world. Finally, the process of determining the quality of included publications referenced the use of the Joanna Briggs Critical Appraisal tools. Specifically, the appropriate tool was selected for each manuscript reviewed. The articles were initially reviewed by the first author, those not meeting a majority criteria, or where questions of quality were raised, were discussed with a second member of the authorship team for clarity, consensus and auditability.

Following publication in early 2018, a subsequent search of the literature was conducted in December 2018 using the same search terms and data bases outlined in the integrative

review publication below, but time limiting the search to literature published between 2017 and 2019 to capture publications that may have been added during this period. A total of 383 articles were found among the databases. The same inclusion and exclusion criteria were applied as described in the original integrative review protocol and only 2 new articles were found to contribute to the body of knowledge concerning the phenomenon of being 'with woman'. One of the articles was this published integrative review (Bradfield, Duggan, et al., 2018) and the second was part of the published findings of this study covered in chapter 7 reporting on midwives' experiences of being 'with woman' in the private obstetric model (Bradfield, Kelly, Hauck, & Duggan, 2018).

The journal Women and Birth was selected for this article due to its global recognition as a prestigious, peer reviewed journal representing high quality manuscripts that are relevant to the midwifery profession reflected in one of the highest impact factors for the Field of Research of midwifery (Impact Factor 1.82 for 2017). Confirmation of adherence to copyright requirements is evidenced in Appendix A. There has been significant interest in the findings of this integrative review since being published which speaks to the demand for further knowledge and evidence around being 'with woman'. Evidence of engagement with this research including article downloads (over 2000), citations and manuscript requests are evidenced in Appendix B.

Reference

Bradfield, Z., Duggan, R., Hauck, Y., & Kelly, M. (2018). Midwives being 'with woman': An integrative review. *Women Birth, 31*(2), 143-152. http://dx.doi.org/10.1016/j.wombi.2017.07.011

Title

Midwives being 'with woman': An integrative review

## Abstract

*Background:* Midwives being 'with woman' is embedded in professional philosophy, standards of practice and partnerships with women. In light of the centrality of being 'with woman' to the profession of midwifery, it is timely to review the literature to gain a contemporary understanding of this phenomenon.

*Aim:* This review synthesises research and theoretical literature to report on what is known and published about being 'with woman'.

*Methods:* A five step framework for conducting an integrative literature review was employed. A comprehensive search strategy was utilised that incorporated exploration in electronic databases CINAHL, Scopus, Proquest, Science Direct and Pubmed. The initial search resulted in the retrieval of 2057 publications which were reduced to 32 through a systematic process.

*Findings:* The outcome of the review revealed three global themes and corresponding subthemes that encompassed 'with woman': 1) philosophy, incorporated two subthemes relating to *midwifery philosophy* and *philosophy and models of care*; 2) relationship, that included the *relationship with women* and the *relationship with partners*; and 3) practice, that captured *midwifery presence*, *care across the childbirth continuum* and *practice that empowers women*.

*Conclusion:* Research and theoretical sources support the concept that being 'with woman' is a fundamental construct of midwifery practice as evident within the profession's philosophy. Findings suggest that the concept of midwives being 'with woman' is a dynamic and developing construct. The philosophy of being 'with woman' acts as an anchoring force to guide, inform and identify midwifery practice in the context of the rapidly changing modern maternity care landscapes. Gaps in knowledge and recommendations for further research are made.

*Keywords:* Midwifery, Midwife, Midwives, with woman, philosophy, midwifery presence

## Introduction

Midwifery is one of the oldest professions in written history (Barrett Litoff, 1982; Fahy, 1998; Grant, 2002). Written records of midwifery and the role of the midwife date back to 1446 B.C. (Barrett Litoff, 1982). In spite of the changes that have occurred within the profession over time, one remaining hallmark of midwifery is the concept of being 'with woman' (Fahy, 1998; Hunter, 2003; Jordan & Farley, 2008).

Being 'with woman' is considered so central to the profession that it has been embedded within descriptors of midwifery practise and standards at national and international levels. The Nursing and Midwifery Board of Australia (NMBA) is the registering and regulatory authority that sets the standards and codes of practice for Australian midwives. The Competency Standards for the Midwife require that midwives "… appreciate the centrality of the relationship with women to the practice of midwifery… she works *with woman* to plan and evaluate care and facilitate decision making by the woman" (NMBA, 2006b, p. 2(p2)). At the time of writing, this is echoed through the NMBA's Code of Conduct (NMBA, 2006a). Being 'with woman' is expressed as a partnership within the Code of Ethics for Midwives and indicates that "the midwife's primary responsibility is toward each woman… in particular the individual woman-midwife partnership… where the partnership focuses on the health and midwifery needs of the woman…"(NMBA, 2008, p. 3). The importance of relationship is supported by the International Confederation of Midwives (ICM) which acknowledges the midwife as a responsible and accountable professional working in partnership with women across the childbirth continuum (ICM, 2014). The *Professional Philosophy of Midwifery* developed by the Australian College of Midwives, is prefaced by the statement "Midwife means 'with woman': this underpins midwifery's philosophy, work and relationships" (ACM, 2004, p. 1).

In light of the centrality of midwives being 'with woman' to the profession of midwifery, it is timely to review what is reported in the literature to gain a contemporary understanding of this phenomenon. As such, the aim of this integrated review is to explore, review and synthesise the literature that reports on the phenomenon of midwives being 'with woman'.

Statement of Significance

What is already known

- 'With woman' is embedded in midwifery philosophy, standards and practice

What this paper adds

- A more holistic understanding of 'with woman' appraising both research and theoretical sources
- A contemporary review of how 'with woman' philosophy intersects with midwifery practise
- Emerging understanding of the dynamic aspects of the woman- midwife relationship in the context of being 'with woman'

## Methodology

There are a range of protocols and frameworks that may be employed when undertaking a review and synthesis of the literature, such as integrative, umbrella and scoping reviews as well as systematic reviews including meta-analysis for quantitative research and meta-syntheses for qualitative research (Whittemore, Chao, Jang, Minges, & Park, 2014). The design of each review protocol acts to scaffold and add rigor to the review and synthesis of literature (Walsh & Downe, 2005; Whittemore et al., 2014). Integrative reviews are used widely in nursing and midwifery research and play a significant role in the development of evidence informed practices (Hopia, Latvala, & Liimatainen, 2016). Integrative literature reviews are characterised by the inclusion a range of knowledge sources including qualitative and quantitative research as well as theoretical publications such as opinion and editorial works(Whittemore et al., 2014). This multifaceted approach assists in presenting a

holistic understanding of the phenomenon under study as it facilitates the appraisal of data derived from a range of methodologies which has an important role in the development of evidence based practice (Hopia et al., 2016; Schneider, 2013; Whittemore & Knafl, 2005). The integrative review presented here, used the methodology as proffered by Whittemore and Knafl (2005). The method involves five stages, namely (1) problem identification (described in the above aim); (2) literature search (search methods and outcomes); (3) data evaluation (quality of included papers); (4) data analysis (results) and (5) presentation (discussion). The use of this methodological framework offers scaffolding which systematises the review process and adds rigor (Hopia et al., 2016).

### Search Method

A comprehensive two-stage approach to searching the literature was adopted and included the following strategies (1) protocol-driven (searching electronic databases as well as hand search) and (2) 'snowballing' (data mining through citation tracking and reference list searches). Search terms "with woman", "midwives" and all of their variations (see example in Table 1) were entered into the following electronic databases: CINAHL, Scopus, Proquest, Science Direct and Pubmed. The search phrase offered challenges due to the preposition 'with', which inadvertently extracted thousands of articles into the collections regardless of the inclusion of the Boolean operators such as inverted commas. To overcome these challenges and to ensure accuracy with entering search terms, a consultant health research librarian was engaged to assist with refining the search strategies. This ensured that the Boolean operators and search terms, minimised the impact of a search term containing a preposition and maximised the potential of capturing publications on the phenomenon under study. For example, the search operator 'N1' enabled searching within the databases of titles and abstracts where the word 'with' appeared near the word 'woman'. A full list of operators used to assist the search strategy are outlined in Table 1.

## Table 1. Search strategy from CINAHL database

| | |
|---|---|
| S1 | (MH "Midwifery+") OR (MH "Nurse-Midwife") OR (MH "Midwifery Service+") |
| S2 | (MH "Midwives+") |
| S3 | Midwife* |
| S4 | Midwive* |
| S5 | S1 OR S2 OR S3 OR S4 |
| S6 | TI with N1 woman |
| S7 | AB with N1 woman |
| S8 | S6 OR S7 |
| S9 | S5 AND S8 |

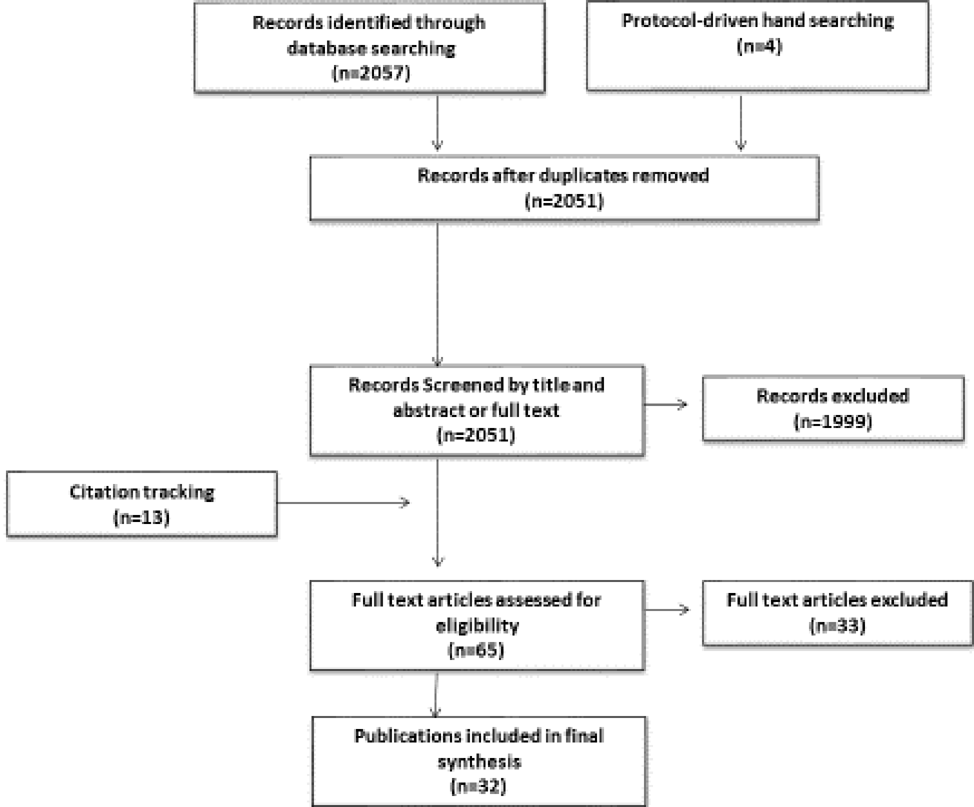
## Key to abbreviations

| | |
|---|---|
| AB | Abstract |
| MH | Mesh Headings |
| N1 | Near |
| S | Search number |
| TI | Title |

Inclusion criteria were set as: research or theoretical articles published in peer-reviewed journals written in English. Suitable publications from 1990 were included as this period aligned with the emergence of modern midwifery writings featuring the phenomenon of midwives being with woman (Carolan & Hodnett, 2007; Isherwood, 1992). Publications were included if they offered descriptions of the phenomenon of midwives being 'with woman'.

Exclusion criteria were applied to publications that did not offer a description of the phenomenon of midwives being 'with woman'. Merely mentioning 'with woman' was not considered sufficient to be included in this review. Articles from newspapers or magazines were excluded as were images and poetry. Because of the aforementioned issue of including a preposition in the principal search term, higher 'false positive' results were returned in the initial search. This added to the work of screening abstracts and full text articles.

A detailed and descriptive account was made regarding all decisions to include or exclude final publications from the review. These decisions are represented in a flow diagram (Figure 1) adapted from the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) framework to enhance transparency and auditability (Blegen, 2010; Hopia et al., 2016).




## Figure 1. Systematic Search Results

Search Outcome

Thirty two publications were identified for review. Figure 1 details the search and selection process from 2057 initial papers to an outcome of 32 publications. The main reasons for exclusion were publications that included the phrase 'with woman' but did not expound or describe this phenomenon further. Other reasons for exclusion were publications that were deemed inadequate after applying the appropriate critical appraisal criteria as outlined under the next section addressing the quality of papers.

## Quality of Included Papers

Whittemore and Knafl (2005) acknowledge the complexity and challenge of evaluating the quality of primary sources, especially when considering both theoretical and research publications. Whilst there are no prescribed 'quality criteria' within the framework for integrative reviews, the publications reviewed in this study were evaluated against the corresponding *Joanna Briggs Institute* critical appraisal tools. Qualitative studies were appraised against the Critical Appraisal Checklist for Qualitative Reviews; (Lockwood, Munn, & Porritt, 2015) this constitutes a 10-item checklist that enables the appraisal of congruity between research methodology and the methods to collect, analyse and interpret data. The three quantitative studies were each appraised with the corresponding Critical Appraisal Checklist for Cohort, Cross Sectional and Prevalence Studies (Briggs, 2016; Munn, Moola, Lisy, Riitano, & Tufanaru, 2015). Twenty two out of a total 26 research publications reviewed were included in this integrative review. Exclusions were based on not meeting relevance criteria rather than the quality of the research. Theoretical publications were reviewed using the *Joanna Briggs Institute* Critical Appraisal Checklist for Text and Opinion (McArthur, Klugárová, Yan, & Florescu, 2015) which constitutes a 6 – item inventory. Thirteen out of the 25 theoretical publications were included which, among other elements, appraised whether the opinion source had professional standing and made reference to extant literature. Exclusions in this domain were predominantly made based on poor reference to extant literature and insufficient qualification of the author's 'standing in the field of expertise'.

## Data abstraction and synthesis

Each publication was reviewed to confirm the inclusion of discussion, description or outcomes of the phenomenon of midwives being 'with woman'. Following evaluation using the relevant critical appraisal checklist, acceptable publications were marked for inclusion and further analysis. The four-stage data analysis method as described in Whittemore and Knafl (2005) was employed. This was underpinned by a constant comparison approach which facilitated the iterative process of identifying emerging themes and sub-themes across primary data sources (Whittemore & Knafl, 2005). At each stage, discussion with co-

authors was conducted until consensus was reached. The first stage (data reduction) meant that data was divided and organised into groups of differing methodologies (qualitative, quantitative and theoretical), the second phase (data display) involved the creation of two main tables to organise research and theoretical based publications. The third stage (data comparison) facilitated the conversion of extracted data into systematic categories which enabled "… the distinction of patterns, themes, variations and relationships" (Whittemore & Knafl, 2005, p. 550(p550)). The qualitative data offered rich descriptions of the phenomenon under study. The quantitative data was used to highlight characteristics of the phenomenon and the relationship between care demonstrating 'with woman' behaviours and outcomes for women, their families as well as midwives. Finally, the theoretical data assisted in providing a broad understanding of the relationship of being 'with woman' to the profession of midwifery. The process of data visualisation is purported to enhance interpretation by providing clarity, and visual comparison of the data (Whittemore & Knafl, 2005). This was achieved in this study and represented in Figure 2. The fourth and final stage (conclusion drawing and verification), served to develop interpretations derived from the previous phase into conclusions or assumptions about the phenomenon of midwives being 'with woman'.

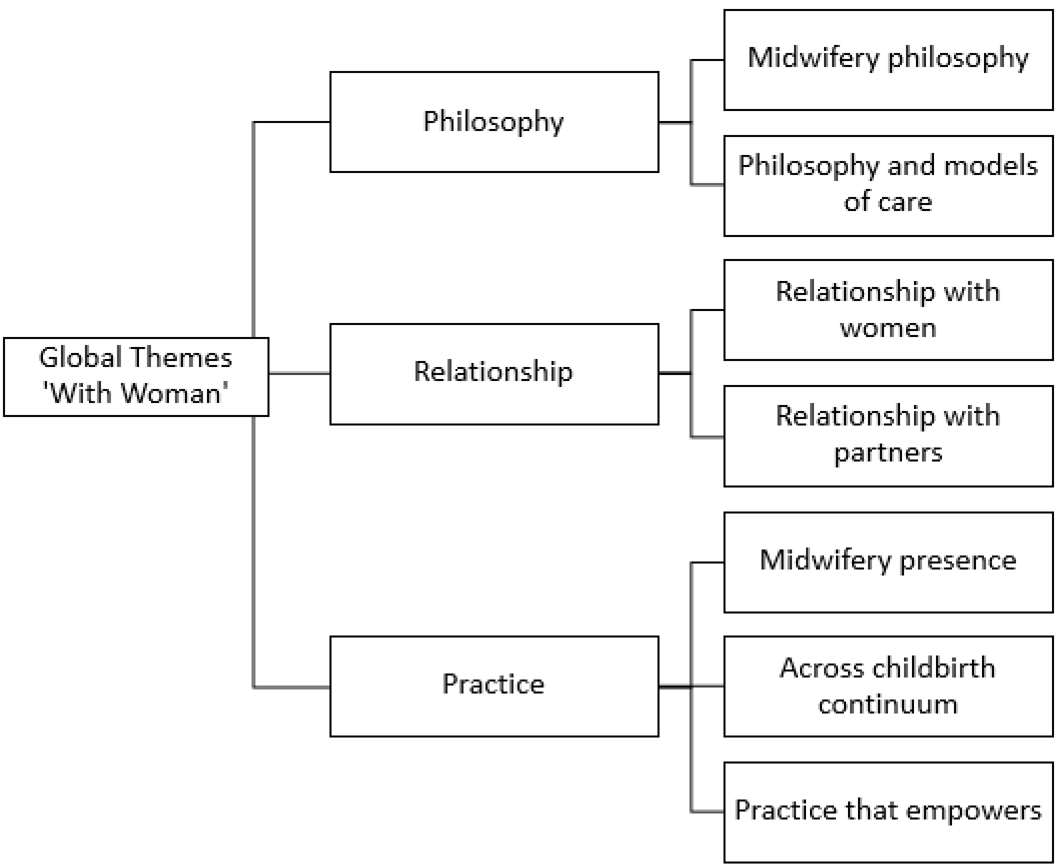



**Figure 2. Global themes and sub-themes of being 'with woman'**

## Search Results

### Types of Publications

The 32 publications comprised: 21 research articles of which there were 16 qualitative (including two grey papers – PhD research), 3 quantitative, and 2 literature reviews. An additional 11 publications were reviewed of which there were 8 editorial, and 3 opinion pieces.

#### Qualitative Research

The sixteen qualitative studies were diverse in the settings and methodological approaches. In Australia, Reed and Rowe (Reed, Rowe, & Barnes, 2016) used narrative inquiry to explore midwifery practice during physiological birth by interviewing 10 midwives. Davis and Homer

(2016) conducted descriptive research wherein 12 midwives working concurrently in primary and secondary birth models were interviewed. Research conducted by Davis and Walker (2011) explored how midwifery practice is constructed by case-loading midwives in New Zealand through interviews with 48 midwives and examining reference documents. Studies conducted in the United States (US) all used a phenomenological approach. Kennedy (1995) explored the essence of nurse-midwifery care by interviewing 6 women about their experience of the same.

In the US, doctoral research by Hunter (2003) is the only study to date, that has specifically sought to explore the phenomenon of midwives being 'with woman'. Hunter used a hermeneutic approach to analyse poetry written by 18 midwives who had referred to providing labour and birth care. Still in the US, Doherty (2010) interviewed 10 nurse-midwives to explore their professional experiences and factors influencing the decision to enter the profession. In the United Kingdom (UK), McCourt (2006) used an observational approach to study how 40 women in either conventional or case-loading models of care were supported to make decisions in their antenatal booking visits. Doctoral research conducted by Barker (2010) used a phenomenological approach to describe the experiences of 7 midwives providing emotional support to new mothers. Lawton and Robinson (2016) also used descriptive phenomenology to explore the experiences of five midwives who were helping women struggling to breastfeed.

The remaining research was conducted in Scandinavian countries. Thorstensson, Ekström, Lundgren, and Hertfelt Wahn (2012) adopted a descriptive approach and used a combination of observation and interview with 7 'triads' (a Swedish midwife, woman and partner) to explore how professional support was offered by midwives during labour. A phenomenological approach was used by Berg et al (Berg, Lundgren, Hermansson, & Wahlberg, 1996) to describe the labour and birth encounters with midwives of 18 Norwegian women. Aune and Amundsen (Aune, Amundsen, & Skaget Aas, 2013) interviewed 10 Norwegian midwives to explore factors influencing their decision to provide continuous presence in childbirth. A 'phenomenology of practice' approach was the basis for research conducted by Jepsen et al (Jepsen, Mark, Foureur, Nohr, & Sorensen, 2017) which used observation and interviews with Danish couples in a case load model after

birthing. Finally, Lundgren and Berg (2007) undertook secondary data analysis of 8 Swedish qualitative studies to explore the central concepts in the midwife/woman relationship.

### Quantitative Research

The three quantitative papers were diverse in their settings and methodological approaches. Hunter (2009) conducted a descriptive correlational study with 238 low risk postpartum women who had birthed in either a hospital or a birth centre in the US. A Positive Presence Index (PPI) tool was used to survey women's experiences of certain qualities considered inherent in Midwifery Presence. A 29-question, 7-step response Likert scale, (Cronbach $\alpha$ .9161) was completed. Scores from the PPI tool ranked the qualities that women felt most strongly associated with positive midwifery presence and then explored relationships between positive presence attributes and the model of care including place of birth. A cross-sectional design was the basis of the research conducted by Jordan and Farley (2008) who explored US graduate midwives' self-efficacy for hallmark midwifery behaviours including therapeutic presence using the Midwife Student Self-Efficacy scale (Cronbach $\alpha$ .78). The findings highlighted relationships between graduates' self-efficacy for hallmark midwifery practises such as therapeutic presence and study variables such as demographic, observed preceptor behaviours and models of care. In Sweden, Hildingsson (2015) conducted a prospective regional cohort study with 1042 women who were surveyed regarding their expectations and experiences of support from partners and midwives during birth. The five areas surveyed were support from partners, support from midwives, control, participation in decision making and midwifery presence during labour and birth. Relationships between these five areas and variables such as antenatal expectations, birth experience and mode of birth were ranked which revealed concepts that indicate elements of midwifery care that women valued (such as midwifery presence) and enhanced their birth experience.

### Theoretical Literature

In line with Whittemore and Knafl's (2005) rich sampling principles, critically appraised theoretical literature was reviewed to offer a comprehensive understanding of the phenomenon of midwives being 'with woman'. A total of eight editorial publications were

reviewed and in the earliest, Fahy (1998), an Australian Professor of Midwifery, served to offer a structure to the historical and philosophical elements of midwives being 'with woman'. Around this time, Tritten (2000) wrote about her search for midwifery philosophy in the US with a focus on being 'with woman'. Still in the US, two authors, Likis and Tharpe (Likis, 2009; Tharpe, 2009) discussed the feminist and emancipatory nature of midwives being 'with woman'. Midwifery educators Carolan and Hodnett (2007) discussed the adoption and integration of being 'with woman' into modern midwifery philosophy in the Australian context. Murphy and King (2013) from the US added strategies for midwives being with woman. The remaining editorials were written by UK and NZ based authors who added commentary to the theoretical aspects of midwives being with woman (Crowther et al., 2016; Power, 2015). Crowther and colleagues explored factors impacting on NZ midwives' resilience and sustainability(Crowther et al., 2016) whilst Power, an academic in the UK discussed the intersection of the art and science of midwifery in the context of modern maternity landscapes (Power, 2015).

The three critically appraised opinion publications were all written by authors based in the UK. Early on, Isherwood (1992) offered commentary on the state of British midwives being 'with woman'. Dabrowski (2014) reviewed the more contemporary manifestations of midwives being 'with woman' in the context of the founding feminist ideals. Finally Hunter (2015) offered some observations on the characteristics of being 'with woman' in the clinical context.

## Findings

The abstracted and synthesised data from research and theoretical publications were analysed using data comparison and thematic analysis. Similar and variant concepts were grouped according to the three global themes that were revealed within the data which were: 'with woman' as midwifery philosophy, 'with woman' as partnership/ relationship and 'with woman' in midwifery practice. Some publications were represented across more than one theme as they had multiple significant findings. The links between the publications reviewed and the resulting themes that developed are clearly identified in Table 2. Under

the three main themes, seven sub-themes were revealed. All themes and sub-themes are represented in Figure 2.

## With Woman as Midwifery Philosophy

### Midwifery Philosophy

The first subtheme in the findings indicates that the midwifery philosophy of being 'with woman' is an important and historical cornerstone of midwifery practice (Fahy, 1998). The modern 're-emergence' of the focus on this phenomenon is in part attributed to the 'professionalisation' of midwifery (Isherwood, 1992). This is supported in editorial writings where 'with woman' is offered afresh as a philosophical construct (Tritten, 2000). Commentary by several midwifery academics (Carolan & Hodnett, 2007; Leinweber & Rowe, 2010) reveals the emergence of discourse about midwives being 'with woman' in the Australian context in the mid 1990's. The philosophical framework provided by the 'with woman' phenomenon was offered as a mechanism to differentiate and provide an holistic alternative to the biomedical approach to childbearing (Carolan & Hodnett, 2007; Dabrowski, 2014; Fahy, 1998; Power, 2015). The philosophical framework of being 'with woman' is viewed as an anchoring force and facilitates midwives moving through a variety of contexts and maternity settings (Davis & Walker, 2011). Being 'with woman' is seen repeatedly as a distinctive and hallmark component of midwifery care (Barker, 2010; Hunter, 2003; Lawton & Robinson, 2016).

### Midwifery Philosophy and Models of Care

Research and theoretical findings indicate that provision of care that is consistent with the midwifery philosophy of being 'with woman' may be impacted by the models of care a midwife works in. It is suggested that working in fragmented and policy-driven medical models is associated with midwives being 'with institution' rather than 'with woman' (Barker, 2010; Davis & Homer, 2016; Doherty, 2010; Isherwood, 1992; Jordan & Farley, 2008; Leinweber & Rowe, 2010; McCourt, 2006). Similarly, it is argued in a number of publications that models of care such as case loading offers the opportunity for midwives to practise within their philosophical constructs and provide responsive and flexible care to

women and their families (Davis & Walker, 2011; Hildingsson, 2015; McCourt, 2006). Other authors contend that the midwifery philosophy of being 'with woman' may act as a vehicle to facilitate quality midwifery care that is not dependent on risk factors or birth place (Davis & Walker, 2011; Doherty, 2010).

## Midwives 'With Woman' as a Partnership/ Relationship

### Relationship with Women

The relationship between midwives and women was highlighted in the literature reviewed as a central component to the practise of being 'with woman' (Aune et al., 2013; Berg et al., 1996; Hunter, 2003; Hunter, 2009; Leinweber & Rowe, 2010). The relationship between a woman and her midwife has been referred to as a partnership (Hunter, 2003; McAra-Couper et al., 2014), professional friendship (Jepsen et al.) and ritual companionship (Reed et al., 2016). The relationship is characterised by inclusiveness, equality, sensitivity, nurturance, trust, flexibility, empowerment, advocacy, care and facilitation of informed decision making (Brown, 2012; Carolan & Hodnett, 2007; Crowther et al., 2016; Hunter, 2003; Hunter, 2015; Hunter, 2002; Hunter, 2009; Jepsen et al.; Kennedy, 1995). The relationship between a woman and her midwife facilitates confidence (Carolan & Hodnett, 2007; McCourt, 2006) , is an essential component in women's reporting of a positive birth experience (Lundgren & Berg, 2007) and is just as necessary in the postnatal period where it may assist the woman to make sense of her birth experience (Hunter, 2015). The benefits also extend to midwives who report that the relationship formed with women is a motivating factor for choosing a midwifery career (Doherty, 2010) and contributes to professional resilience and sustainability (Crowther et al., 2016; McAra-Couper et al., 2014).

### Midwives 'With Women' and birth partners/ significant others

The phrase 'with woman' has in the past, been criticised in the literature for potentially excluding birth partners and significant others (Carolan & Hodnett, 2007). When discussing midwives' professional relationship of being 'with woman', invariably, it is within the context of the social structures that the woman posits herself (Carolan & Hodnett, 2007). The importance of including birth partners and the woman's significant others in the care

provided to women is recognised (Crowther et al., 2016; Hildingsson, 2015; Jepsen et al.; Thorstensson et al., 2012). The concept of midwives' relationship with the woman's family and significant others is acknowledged (Crowther et al., 2016). When midwives work to sustain a relationship with the woman and her partner this has been found to alleviate feelings of anxiety and helplessness for both women and their partners (Thorstensson et al., 2012). Research supports that the model of case loading may benefit not only the woman but also her partner and facilitate the partner's inclusion in the care of the labouring woman (Jepsen et al.).

## With Woman in Midwifery Practice

### Midwifery Presence

The concept of midwifery presence is firmly established in the theoretical results written by midwives in the US (Jordan & Farley, 2008; Kennedy, 1995). This has been adopted into the writings from the Scandinavian countries (Aune et al., 2013), the UK and more recently in Australia (Davis & Homer, 2016). Presence as a manifestation or embodiment of midwives' being 'with woman' is characterised by support of the woman's emotional, physical, spiritual and psychological needs (Thorstensson et al., 2012) and is seen to contribute to a sense of calm and security (Davis & Homer, 2016; Thorstensson et al., 2012). Some assert that being present with the woman is a spiritual concept (Hunter, 2003; Hunter, 2015; Hunter, 2002). It is noted that providing presence does not necessarily require a specific or pre-determined outcome, rather, that the focus is to just be 'with woman' (Berg et al., 1996; Davis & Homer, 2016; Hunter, 2009). Findings from Swedish research differentiated the provision of basic support and a midwife's presence (Hildingsson, 2015) and describes the phenomenon of 'absent presence' where a midwife may physically be in the room but not providing the support characteristic of midwifery presence (Berg et al., 1996).

### Being With Woman across the Childbearing Continuum

Whilst much of the discussion in the literature included of midwives being 'with woman' is situated in the labour and birth setting (Berg et al., 1996; Davis & Homer, 2016; Hildingsson, 2015; Hunter, 2003; Hunter, 2002; Hunter, 2009; Lundgren & Berg, 2007; Reed et al., 2016;

Thorstensson et al., 2012), there are some emerging writings that address the practice of being 'with woman' across the continuum of childbearing. In the antenatal setting, a characteristic of midwives being 'with woman' is the practice of effective communication (McCourt, 2006) that facilitates education of women and their support partners as well as informed decision making (Likis, 2009; Murphy & King, 2013). In the postnatal setting, midwives report that practicing from a 'with woman' philosophy facilitates a 'pro-mother' approach to addressing breastfeeding problems rather than forcing institutional, political or policy agenda (Lawton & Robinson, 2016). When midwives form a relationship 'with woman', this can assist women to make sense of, and in engage in, their birthing experiences by creating 'space' for women to know themselves and reveal their feelings and desires (Hunter, 2015).

### Being 'With Woman' Empowers

According to the literature, being 'with woman' has the capacity to provide political agency by validating the female experience of childbirth and provides a platform for empowerment (Hunter, 2015; Tharpe, 2009). The role that midwives adopt in facilitating informed decision making also serves to enhance the agency and power of the woman and midwives alike (Aune et al., 2013; Hunter, 2015; Likis, 2009; Lundgren & Berg, 2007; McAra-Couper et al., 2014; Murphy & King, 2013). The philosophy of being with woman creates a therapeutic environment that is necessary for advocacy and empowerment (Berg et al., 1996; Davis & Walker, 2011; Hunter, 2015) and can act as an antidote to the dehumanising, 'systems'-based approach to childbirth (Dabrowski, 2014; Fahy, 1998; Hunter, 2003).

## Discussion

The findings of this integrative review have demonstrated evidence of an intentional development and integration of the midwifery philosophy of being 'with woman' by the profession of midwifery, within the last 20 years. The conceptualisation and embedding of 'with woman' practices have been facilitated by research and theoretical literature from midwifery leaders around the world. As well as reporting on the concept of being 'with woman', the insight gained through this integrative review has served to 'map' the

progression and development of 'with woman' practices and to highlight how contemporary health care practices may intersect with the provision of 'with woman' care. The findings serve to endorse and augment the Australian College of Midwives' assertion in their current philosophical statement, that being 'with woman' offers a foundation to the philosophy, relationships and practises of midwives (ACM, 2004).

There is agreement between research findings and professional commentary, that midwives being 'with woman' is a fundamental and hallmark midwifery practice. Writings from as early as 1998 indicate the facility of the 'with woman' philosophy to offer an alternative to the techno rational practices of a biomedical approach to childbirth (Carolan & Hodnett, 2007; Dabrowski, 2014; Fahy, 1998; Power, 2015). How this intersects with the applied practice of being 'with woman' is seen in the natural (vs biomedical) approaches to childbirth that are characteristic of 'with woman' midwifery care (Reed et al., 2016). Whilst there is evidence that medically – focussed models of care may impact the provision of 'with woman' care, there is also an emerging proposition that being 'with woman' may actually facilitate movement between all care models and is not risk or birth place dependent (Davis et al., 2011). Further research is warranted to enhance understanding about the intersection of midwives being 'with woman' within the context of a variety of care models.

Whilst the relationship with the childbearing woman is a previously understood feature, the emergence of insight around the impact and importance of midwives' professional relationship with a woman's partner is new information and adds to the understanding of contemporary 'with woman' practices. This innovative and welcome perspective into the experience of birth support partners highlights that 'with woman' care extends to incorporate partners or the woman's significant others and enhances their experience of childbirth (Crowther et al., 2016; Jepsen et al.; Thorstensson et al., 2012). This development is consistent with the progression in other professions such as counselling and nursing, who recognise the importance of supporting the individual within the context of their social constructs (Coco, Tossavainen, Jaaskelainen, & Turunen, 2011; Lindsay, 2016; Romero, Riggs, & Ruggero, 2015).

Whilst the reference to ‘midwifery presence’ is yet to be found in Australian midwifery vernacular, the concept appears in research and theoretical writings globally and describes the manifestation of how midwives are ‘with woman’ (Aune et al., 2013; Davis & Homer, 2016; Pembroke & Pembroke, 2008). With origins in the field of philosophy, the broader concept of presence or, ‘therapeutic presence’, first appeared in nursing literature in the late 1970’s (Boston & Bruce, 2014; McKivergin & Daubenmire, 1994) and has since been explored in diverse fields such as teaching (Solomon & Nashat, 2010) and most recently, neuroscience(Geller & Porges, 2014). In line with the dynamic and progressive expressions of midwives being ‘with woman’ in the theoretical and practical contexts, the adoption of midwifery presence in modern writings assists to describe the more applied elements of the complex ‘with woman’ phenomenon.

The majority of literature addresses midwives being ‘with woman’ in the context of support offered during labour and birth (Berg et al., 1996; Davis & Homer, 2016; Hildingsson, 2015; Hunter, 2003; Hunter, 2002; Hunter, 2009; Lundgren & Berg, 2007; Reed et al., 2016; Thorstensson et al., 2012). There are recent writings that have emerged however, where ‘with woman’ practices are explored within the context of antenatal and postnatal care. Further research is warranted into how midwives exhibit being ‘with woman’ in antenatal and postnatal periods and settings.

Another feature of ‘with woman’ philosophy bearing impact on midwifery practice, is a transference of ‘power’ to the woman through the facilitation of informed decision making and the creation of ‘space’ that encourages this (Hunter, 2015; McCourt, 2006). This is noted as being in direct contrast to the biomedical approach to childbearing which adopts a paternalistic approach to care (Dabrowski, 2014; Fahy, 1998; Power, 2015). The outcome of midwives being ‘with woman’ in a way that empowers women and their families, illustrates again, the impact of professional philosophy on practice. The constituents of empowerment are generally intrinsic which means that manifestations may be more discrete and therefore more challenging to qualify than other elements of being ‘with woman’ (Shimamoto & Gipson, 2015). Despite this, the impacts are no less important for women, or indeed, midwives (Power, 2015). This emphasises all the more, the importance of having a contemporary understanding of the professional philosophy that advises practise.

The strength of this review lies in the integration of both research and theoretical data to develop a holistic picture of what is currently reported on midwives being 'with woman'. By employing this integrative and inclusive methodology, knowledge generated by research as well as wisdom shared through midwifery leaders' experience has been critically appraised and synthesised. This review approach reflects modern midwifery practice itself, that is an artful blend of care informed by research based evidence as well as professional intuition where positivist and constructivist approaches are joined to provide woman-centred, holistic care (Power, 2015).

Within contemporary literature, most of what is understood about midwives' experiences of the phenomenon of being 'with woman' is derived from research that describes midwifery care in general from women's perspectives or commentary from midwifery leaders. A significant finding of the review was the distinct lack of research that has explicitly explored the phenomenon of being 'with woman' from the perspective of practising midwives. In order to gain a more comprehensive understanding of this founding philosophical construct, further research is recommended, specifically, to understand midwives' experiences of the phenomenon of being 'with woman'.

The outcome of the search revealed a number of articles that made isolated reference/inference to a midwife being 'with woman' but did not proceed to report on the phenomenon of midwives being 'with woman'. This adds strength to the findings made in this study, that whilst the philosophical and theoretical elements of being 'with woman' are apparently well embedded and accepted within the midwifery profession throughout the developed world, there is a gap in understanding how 'with woman' practices might be understood or experienced by midwives. The importance of determining this is three fold. Firstly, Sandall et al (2013) presents compelling evidence that 'with woman' approaches to childbearing which may be supported by midwifery-led models of care such as those found in caseloading, midwifery group practices and privately practising midwives, is associated with good outcomes and is desired by women all over the world (Sandall, Soltani, Gates, Shennan, & Devane, 2013). Understanding and preserving midwifery practice, inspired by the philosophical mandate to be 'with woman' will ensure that into the future, women and their families can continue to receive this exemplary care. Secondly, the capturing of

practices driven by professional philosophy serve to add to the body of knowledge and wisdom around the 'workings' of the profession. Understanding midwives perspectives of being 'with woman' in a range of models, and; with women whose health, or choice, requires a transition or movement between models is needed.  Having records of this knowledge is important in an increasingly medicalised society as it can serve as an anchor to re-focus and underpin the care that is provided by midwives (Davis & Walker, 2011). Finally, the mandate to develop graduates that are not just technically proficient practitioners but midwives who enter the workforce imbued with professional philosophy and theoretical knowledge that intersects with midwifery practice is keenly felt (Fahy, 1998; Power, 2015). Having a contemporary understanding of the expressions of the 'with woman' philosophy will enable this to be incorporated into the practise dispositions of future midwives.

## Conclusion

This review brings together research and theoretical evidence to report on the phenomenon of midwives being 'with woman'. There is agreement between both paradigms regarding the fundamental elements of midwives being 'with woman'. The themes and sub-themes are supported by a range of research approaches as well as theoretical writings from professional leaders. New and emerging developments of how 'with woman' practice translates into the clinical setting have been noted. The findings contribute a contemporary and holistic understanding of the phenomenon of midwives being 'with woman'. Gaps in knowledge have also been identified, specifically the lack of evidence around midwives' experiences and understanding of being 'with woman', and recommendations for research in this arena have been made.

**Table 2 Characteristics of the 34 included publications**

| 1st Author/ Year/ Country of Origin | Focus | Publication Type | Data Collection Method | Sample | Results | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Midwifery Philosophy | Philosophy & Models of Care | Relationship with women | Relationship with woman's significant others | Midwifery Presence | Childbearing continuum | Empowerment |
| **Aune 2013 NOR** | Continuous presence of a midwife | PR Qual. Desc. | Interviews | 10 midwives | | | ✓ | | ✓ | | ✓ |
| **Barker 2010 UK** | Providing emotional support to women | PR Qual. | Interviews | 7 midwives | ✓ | ✓ | ✓ | | | | |
| **Berg 1996 NOR** | Labour and birth encounters | PR Qual. Phenom. | Interviews | 18 women | | | ✓ | | ✓ | | ✓ |
| **Brown 2012 UK** | Teaching empathy and sensitivity | PR Qual. Ethnog. | Observ. & Interviews | 56 midwifery students & supervisors | | | ✓ | | ✓ | | |
| **Carolan 2007 AUS** | WW philosophy | Editorial | - | - | ✓ | | ✓ | ✓ | | | |
| **Crowther 2016 UK/ NZ** | Sustainability and resilience in midwifery | Editorial | - | - | | | ✓ | ✓ | | | |
| **Dabrowski 2014 UK** | With woman | Opinion | - | - | ✓ | | | | | | ✓ |
| **Davis 2011 NZ** | Case loading bridging normal/ abnormal | PR Qual. Desc. | Interviews | 48 midwives | ✓ | ✓ | ✓ | | | | ✓ |
| **Davis 2016 AUS/ UK** | Place of birth: impact | PR Qual. Desc. | Interviews | 12 midwives | | ✓ | | | ✓ | ✓ | |

| 1st Author/ Year/ Country of Origin | Focus | Publication Type | Data Collection Method | Sample | Results | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Midwifery Philosophy | Philosophy & Models of Care | Relationship with women | Relationship with woman's significant others | Midwifery Presence | Childbearing continuum | Empowerment |
| **Doherty 2010 US** | Voices of Midwives | PR Qual. Phenom. | Interviews | 10 Nurse - Midwives | | ✓ | ✓ | | | | |
| **Fahy 1998 AUS** | Being vs doing midwifery | Editorial | - | - | ✓ | | | | | | ✓ |
| **Hildingsson 2015 SWE** | Birth expectations | PR Quant. Cohort Study | Question. | 1042 women | | ✓ | ✓ | ✓ | ✓ | | |
| **Hunter 2002 US** | Being with woman | SR Literature Review | Secondary data | Databases search 1985-2000 | | | ✓ | | ✓ | ✓ | |
| **Hunter 2003 US** | Being with woman during birth | PR Qual.Herm. Phenom. | Secondary data | Poetry written by midwives | ✓ | | ✓ | | ✓ | ✓ | ✓ |
| **Hunter 2009 US** | Being with woman during labour and birth | PR Quant Desc. Corr. | Question. | 238 women | | ✓ | ✓ | | ✓ | | |
| **Hunter 2015 UK** | Claiming midwifery space | Opinion | - | - | | | ✓ | | ✓ | ✓ | ✓ |
| **Isherwood 1992 UK** | Are midwives with woman | Opinion | - | - | ✓ | ✓ | | | | | |
| **Jepsen 2016 DEN** | Couples' experiences of Case loading | PR Qual. Phenom. of Practice | Observ. & Interviews | 10 couples | | | ✓ | ✓ | | | ✓ |
| **Jordan 2008 US** | Therapeutic Presence | PR Quant. Cross sectional | Question. | 22 midwifery students | ✓ | ✓ | | | ✓ | | |

| 1st Author/ Year/ Country of Origin | Focus | Publication Type | Data Collection Method | Sample | Results | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Midwifery Philosophy | Philosophy & Models of Care | Relationship with women | Relationship with woman's significant others | Midwifery Presence | Childbearing continuum | Empowerment |
| **Kennedy 1995 US** | Essence of nurse-midwife care | PR Qual. | Interviews | 6 women | | | ✓ | | ✓ | | |
| **Lawton 2016 UK** | With women who have breastfeeding problems | PR Qual. Phenom. | Interviews | 5 midwives | ✓ | | | | | ✓ | |
| **Leinweber 2008 AUS** | Secondary traumatic stress in midwifery | SR Literature review | Secondary data | Databases search | ✓ | ✓ | ✓ | | | | |
| **Likis 2009 US** | With women: unintended pregnancy | Editorial | - | - | | | | | | ✓ | ✓ |
| **Lundgren & Berg 2007 SWE** | Concept in the Midwife-woman relationship | SR Literature review | Secondary data | 8 Qual studies | | | ✓ | | | ✓ | |
| **McAra-Couper 2014 NZ** | Sustaining midwifery practice | PR Qual. Desc. | Interview | 11 midwives | | | ✓ | | | | ✓ |
| **McCourt 2006 UK** | Choice & control in antenatal booking | PR Qual. | Observ. & Interview | 40 women | | ✓ | ✓ | | | ✓ | |
| **Murphy & King 2013 US** | Communication essential to being with woman | Editorial | - | - | | | | | | ✓ | ✓ |
| **Power 2015 UK** | Contemporary midwifery | Editorial | - | - | ✓ | | | | | | |

| 1st Author/ Year/ Country of Origin | Focus | Publication Type | Data Collection Method | Sample | Results | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Midwifery Philosophy | Philosophy & Models of Care | Relationship with women | Relationship with woman's significant others | Midwifery Presence | Childbearing continuum | Empowerment |
| **Reed 2016 AUS** | Midwifery practice during birth | PR Qual. Narrative | Interviews | 10 midwives 10 women | | ✓ | ✓ | | | | |
| **Tharpe 2009 US** | Midwifery legacy | Editorial | - | - | | | | | | | ✓ |
| **Thorstensson 2012 SWE** | Support during labour | PR Qual. | Observ. & Interview | 7 midwives 7women 7 partners | | | ✓ | ✓ | ✓ | ✓ | |
| **Tritten 2000 US** | A new season in midwifery | Editorial | - | - | ✓ | | | | | | |

Key to Abbreviations

| AUS | Australia | Phenom. | Phenomenology |
|---|---|---|---|
| Corr. | Correlational | Qual. | Qualitative |
| DEN | Denmark | Quant. | Quantitative |
| Desc. | Descriptive | Question. | Questionnaire |
| Ethnog. | Ethnography | SR | Secondary Research |
| NOR | Norway | SWE | Sweden |
| NZ | New Zealand | UK | United Kingdom |
| Observ. | Observation | US | United States |
| PR | Primary Research | | |

## Chapter Conclusion

This chapter has presented the final manuscript of a published integrative review. The findings of the review highlighted the gaps in knowledge and specifically indicate the need for further research on the phenomenon of being 'with woman' as it is experienced and understood by midwives within the variety of clinical contexts.

The next chapter presents review of the various research paradigms and methodologies available. A description of, as well as a rationale for, the selection of descriptive phenomenology as the methodology is provided. The research design and methods is described and a summary of the features of this study that enhance rigor is presented.

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# Chapter Three • Methodology

## Chapter Introduction

This chapter describes and provides a rationale for the selection of descriptive phenomenology as the research methodology in this study. The methods employed are presented including the research aim and objectives, recruitment, data collection, management and analysis. The elements of the study that provide and evidence rigor in research are outlined. Ethical considerations of the study are explored and a timeline of the research process is presented. The first section commences with a detailed discussion on how the role of research paradigms was reviewed in order to select the most appropriate methodology to address study aims and objectives.

## Research Paradigm

Research paradigms serve to guide inquiry and also act to declare the ontological, epistemological and methodological stance adopted by the researcher (Denzin & Lincoln, 2018, p. 42). An alternative phrase to research paradigms is offered by Creswell (2018) who maintains that there are four main 'worldviews' each with their own epistemological, ontological and methodological constructs namely, post-positivism, constructivism, transformative and pragmatism . There is little agreement on the classification of research paradigms but similarities exist in each interpretation. Denzin and Lincoln (2018) report the following paradigms; positivist, post-positivist, constructivist, critical theory, interpretivist as well as heralding emerging post-interprevist and hybrid paradigms. While Francis, Chapman, and Whitehead (2016) present three paradigms: positivist, critical and interpretive.

Some authors suggest that the intentionally 'open posture' of qualitative research resists attempts to impose an over-arching paradigm over a research project (Denzin & Lincoln, 2018). Others indicate that the philosophical 'rudder' of research paradigms inevitably influence research praxis and should be declared (Creswell, 2018).

Despite the differences in classifying research paradigms, there is general consensus in the underpinning constructs. In synopsis, a positivist research paradigm is guided by a deterministic (also known as reductionist) philosophy which asserts that objective measurement of reality can result in 'absolute' truth by considering a cause and effect approach. Here, theory supports the formation of a hypothesis which is tested using quantitative approaches and is either refuted or supported (Francis et al., 2016). Criticism of this paradigm lie in its inability to consider the human experience within its context (Creswell, 2018; Francis et al., 2016). A critical paradigm utilises a post-positivist philosophy adopting a postmodern stance that seeks to understand and explore social structures and phenomena with a view to enhancing agency, empowerment and generating social change (Denzin & Lincoln, 2018). Qualitative research methodologies such as feminist, critical ethnography and action research are employed which critique existing social contexts in partnership with research participants and are informed by the critical paradigm (Denzin & Lincoln, 2018; Francis et al., 2016). Interpretivist paradigms are occasionally classified along with constructivist paradigms and seek to explore and understand meaning within the context that participants find themselves. Qualitative methodologies such as phenomenology, ethnography and grounded theory are commonly framed by interpretivist or constructivist paradigms (Creswell, 2018; Francis et al., 2016).

Historically it was accepted that research was divided into two main approaches; classified as either qualitative and quantitative, however new discourses have emerged suggesting that the previously discrete divide between qualitative and quantitative research approaches are blurring (Denzin & Lincoln, 2018). This development has resulted in three approaches being offered namely, qualitative, quantitative and mixed methods. Qualitative research seeks to understand, interpret or make sense of the meanings people attribute to phenomena; whereas quantitative research seeks to test theory by determining the relationship between two or more variables which may be measured and analysed using statistical techniques (Creswell, 2018; Denzin & Lincoln, 2018). Mixed methods research is used to collect and analyse both qualitative and quantitative data when insight might be enhanced by integrating

these components "...within a single study and in such a way as to be mutually illuminating, thereby producing findings that are greater than the sum of parts" (Woolley, 2009, p. 7) .

Given the potential for the aforementioned myriad of paradigms, approaches and methodologies, there are several factors which should be considered by the researcher when considering selection, such as the research problem or question as well as epistemological and ontological stances. If measuring the relationship between two or more study variables is desirable; or, consideration of the effect of various interventions is warranted then a quantitative approach is recommended (Denzin & Lincoln, 2018). When phenomena need to be explored or better understood because of a lack of previous research, or the concept has not been explored with a certain group of people or social context, qualitative approaches are advised. When neither the qualitative or quantitative approach on its own would be sufficient to provide an understanding then a mixed methods approach might be considered (Creswell, 2018).

Because the aim of this research was to explore midwives' perceptions and experiences of being 'with woman', an important but previously unexplored phenomenon, it was clear that a qualitative approach was warranted. The next step was to select from the variety of qualitative research methodologies available to explore the human experience. Several methodological approaches were considered; the review process and considerations are presented.  Firstly, grounded theory was considered in light of its role in the development of theories of basic social process within a specific context (Starks & Brown Trinidad, 2007). Because the current knowledge of being 'with woman' existed almost solely in the philosophical and proposed theoretical realms, the researcher was cautious in considering the suitability of this methodology to address a gap in knowledge  and arrive at a  description of commonalities in the applied practices and experiences of being 'with woman'. A qualitative descriptive approach was also considered but was not deemed a 'best fit' to examine the complex phenomenon of being 'with woman' in sufficient detail. This decision was made  due to criticisms of the lack of philosophical, theoretical and methodological framework to scaffold this research approach (Whitehead, Dilworth, &

Higgins, 2016a). The methodology of ethnography was also considered for its focus on describing and interpreting cultural behaviour. Ultimately, this methodology was not selected because the focus of the research was exploring the phenomenon rather than the culture itself; also ethnography provides a limited role in revealing the perceptions of a phenomenon which was a focus of this research (Polit & Beck, 2014; Whitehead et al., 2016a).

Ultimately, the research methodology of phenomenology was selected, renowned for describing perspectives, understandings and experiences of the phenomenon under study. This approach is acknowledged for the capacity to reveal the necessary and essential features of a phenomenon derived from the rich and in-depth descriptions of the 'lived experience' provided by study participants (Bondas, 2011; Whitehead et al., 2016a).

## Philosophy of Phenomenology

The origins of the research methodology of phenomenology lie in the philosophy of phenomenology. Edmund Husserl, a mathematician, was inspired by his mentor Franz Brentano and sought to offer a way to scientifically consider and describe the essential structures of phenomena (Davidsen, 2013). This stance was borne out of an understanding that the reductionist and positivist approaches of other methodologies were insufficient to explore human experiences and phenomena (Giorgi, 2000; Husserl, 1970; Whitehead, Dilworth, & Higgins, 2016b).

In phenomenological research, perception of phenomena are considered to be the most trustworthy and primary source of knowledge. Individual perceptions contribute to hyletic descriptions that form the essential structures and reveal the essences of experiencing the phenomenon under study (Finlay, 2013; Husserl, 1965; Moustakas, 1994; Williford, 2013). Phenomenology seeks to understand the lived experience of the same phenomenon as it appears to different individuals and in so doing, reveals the eidetic structures which are the necessary and similar constructs of the phenomenon (Moustakas, 1994).

The philosophical framework functions to provides structure and purpose to the practice of phenomenological research which adds rigor (Lopez & Willis, 2004). The philosophy of phenomenology is dynamic and has continued to develop since its inception. Whilst exploring the lived experience as well as revealing meaning and constituents of phenomena remains the central tenet, different components of philosophy that inform the research methodology have evolved. The changes within the philosophy have impacted and correspondingly, advised the methodological processes of conducting research (Davidsen, 2013). Several distinct phenomenological methodologies have evolved which include, descriptive, hermeneutic, interpretive phenomenological analysis, as well as lifeworld and dialogical approaches (Finlay, 2013).

## Phenomenological Research Methodology

Broadly, it is considered that there are two main 'branches' within the methodology of phenomenology which have given rise to various 'sub branches' or ways of applying the dynamic philosophy of phenomenology to scientific research (Dowling & Cooney, 2012; Polit & Beck, 2014) . The founding methodology known as descriptive phenomenology was offered by Husserl (Husserl, 1965; Lopez & Willis, 2004; Whitehead et al., 2016a). Husserlian or descriptive phenomenology has three central tenets that make it distinct from other versions of the methodology, in brief, these are:

1. Achievement of transcendental subjectivity, where the impact of the researcher on the study is constantly scrutinised and neutralised through the process of 'phenomenological reduction' so as not to influence the phenomenon under study

2. Adoption of a phenomenological attitude and suspension of a 'natural attitude', characterised by an 'openness' to the phenomenon being studied which is maintained throughout all stages of data collection and analysis.

3. Expression of essences of the phenomenon. Unlike other forms, descriptive phenomenology is not interested in the pursuit of defining or the interpretive theorising of phenomena. Rather, by utilising the process of free imaginative variation,

the researcher transforms the 'meaning units' offered by participants into necessary and essential essences of the phenomenon under study (Finlay, 2013; Husserl, 1965, 2012; Moustakas, 1994).

Interpretive Phenomenology, the second main 'branch' of phenomenology, was developed by Heidegger who was a student of Edmund Husserl. Unlike Husserl, Heidegger asserted that the purpose of phenomenological inquiry should be to expose the 'being' of the phenomenon in relation to the participant's position (in the context of an experience) rather than its essences (Converse, 2012; Giorgi, 2007; Whitehead et al., 2016a). The core features of this approach include the exploration of "... the relationships between self, being, meaning, existence and temporality" (Whitehead et al., 2016a, p. 99). Another departure from the 'descriptive branch' was the assertion that not only is bracketing of personal assumptions not possible, but it is not desirable. In interpretive, often known as Heiddegerian phenomenology, the fore-sight achieved through personal assumptions and knowledge are utilised to facilitate the interpretation required in this method which maintain that humans exist within the context of their own experience and interpretations (Converse, 2012; Dowling & Cooney, 2012).

## Choice of Descriptive Phenomenology

The rationale for selection of the methodology of phenomenology to frame this study has been demonstrated in light of the research aim to understand more about the important phenomenon of being 'with woman'. Particular consideration has been given to the methodology's usefulness to understand the same phenomenon as it manifests itself to different individuals (Flood, 2010; Giorgi, 1997). By understanding midwives' perceptions and experiences of the phenomenon, it was considered that a better understanding of the necessary and invariant features of the phenomenon which provided a useful foundation for understanding how these 'essences' might be manifested within the various maternity settings, could be ascertained.

In considering the methodology best suited to conduct this research, the decision was made to select descriptive phenomenology and was based on the assertion that the methodology is useful for revealing essences of a phenomenon in a way that "...neither adds nor subtracts from the invariant intentional object arrived at, but describes it precisely as it presents itself" (Giorgi, 2009, p. 137). This assertion was considered especially important as there is little existing evidence to act as a guide to the phenomenon of being 'with woman' and considering that all knowledge generated in this study would offer new and foundational evidence. The researcher deliberated that having an understanding of the constructs of the phenomenon so important to the profession of midwifery that is described 'as it presents itself' to the midwife participants was crucial.

Secondly, the process of phenomenological reduction central and unique to the practice of descriptive phenomenology facilitated the researcher to be 'fully present' to the midwives and their descriptions, by suspending one's natural attitude and any prior experience or knowledge about the phenomenon under study (Finlay, 2013; Giorgi, 2009). It was also considered to be useful to the professional community to provide an opportunity to "...understand better what it is like for someone to experience that phenomenon" (being with woman) which is the focus of descriptive phenomenology (Polkinghorne, 1989, p. 46).

Another feature inherent to the methodology of descriptive phenomenology is the focus on arriving at descriptions of essences of the phenomenon under study (Giorgi, 1997; Whitehead et al., 2016a). Given the aforementioned gap in empirical knowledge about being 'with woman', the focus provided by this methodology could provide an applied understanding of the phenomenon by describing the necessary and invariant features. Given the practice-based nature of the profession of midwifery, producing descriptions of being 'with woman' as it 'presented' to midwives themselves was considered to be highly valuable.

A final feature of descriptive phenomenology which influenced the decision to choose this form of phenomenological research was the importance of context. It is asserted

that the aim of descriptive phenomenology is "...to arrive at a structural understanding of specific and concrete experiences by being fully and critically present to situations where the desired experiences take place" (Giorgi, 2002, p. 9). In the case of this study, the context in which the midwives worked, whether they had the opportunity to work with women they had previously met, or not, was significant and relevant. It is considered impossible to gain a global sense of an experience by separating the constituents of the phenomenon from the context in which they are experienced (Giorgi, 2002). Doing this, it is suggested, would result in artificial explanations because of the inextricable link of experiences of a phenomenon to the context in which it is experienced (Castro, 2003).

## Phenomenological Reduction and Reflexivity

Having discussed the rationale for selection of Husserlian or descriptive phenomenology, it is pertinent to reference how the guiding constructs of this methodology were applied to this study. First and foremost, it is critical to address the requirement and role of phenomenological reduction also known as the 'epoché' in phenomenological research which are considered both mutually dependent and essential for the conduct of descriptive phenomenological research (Finlay, 2008). The phenomenological attitude involves a suspension of the researcher's natural attitude towards the phenomenon under study and replaces it with a flexible and open attitude, that some authors assert is characterised by a posture of wonder (Dowling & Cooney, 2012; Errasti-Ibarrondo, Jordán, Díez-Del-Corral, & Arantzamendi, 2018) and anticipation of discovery (Finlay, 2008). Adopting the phenomenological attitude is achieved through the process of researcher reflexivity (Todres, 2007). This process involves a critical self-dialogue that considers the researcher's 'natural attitude' and integration within their lifeworld that may not be immediately or 'naturally' apparent (Bevan, 2014; Bondas, 2011; Finlay, 2008). Strategies for strengthening reflexivity to enhance awareness of and bracket personal biases utilised in this study included journaling (Krefting, 1991; Ortlipp, 2008) and external referencing through a research committee comprised of experienced qualitative researchers (Rettke, Pretto, Spichiger, Frei, & Spirig, 2018). The process of phenomenological reduction is intended to reveal

and facilitate "... a new way of experiencing, of thinking, of theorising" beyond that which would be possible in the researcher's 'natural' attitude or ways of thinking about the phenomenon under study (Husserl, 1970, p. 152).

In the case of this study, the researcher had been a midwife for 16 years, working in a variety of rural and metropolitan maternity settings within Western Australia (WA). Some of the motivations for undertaking the research have already been discussed in Chapter One (the introductory chapter). After a move to an academic role teaching entry to registration midwifery students, the researcher worked for 2 years prior to enrolling in doctoral studies. The researcher had past professional association with eight of the midwives interviewed. The potential for influence on participants' responses was considered minimal as five participants were known through professional connections but had not worked clinically with the researcher and three had briefly worked with the researcher in the clinical setting, with no power differential in any of these relationships; and over five years prior to this research commencing.

Because of the extensive clinical experience and the impression made by the collective 'call from the profession' to be 'with woman' however broadly this was described; the author held views and perceptions based in her midwifery experience and knowledge about the meaning and expressions of being 'with woman'. These were recorded as one of the first entries in the Research Journal which was commenced prior to data collection. This journaling was a useful practice as it was possible to return to this record and practice the reflexivity required to be 'true' to the process of being a 'valid instrument' of data collection and analysis. An excerpt from the Research Journal dated 18th November 2017 which was an entry written early in the data collection process is provided in Figure 1 below.

18th November 2017

**Pre Interview 3**

This midwife works in a KM (known midwife) model. I'm cautious about gaining this midwife's respect by being both professional and approachable. Conscious of bracketing any expectations of descriptions of a midwife working in this model.

**Post Interview 3**

This interview went well – again no struggle with getting descriptions to flow. I found myself wrestling internally with wanting the midwife to give me certain descriptions and getting frustrated when she did what I felt was 'stopping short' of saying what I 'expected' of this model. I was able to reign this in and just listen to the descriptions. The data was rich and full of experience-based descriptions which was good. It felt like there was lots of repetition in what she was saying which didn't bother participant 3. I also found myself coming to a 'middle ground' understanding sometime during/ just after this interview where I acknowledged, yes, I need to be aware and conscious of my role as the research 'instrument' but, equally, I'm not solely responsible for the data that ensues. This was quite freeing and allowed the interview to flow 'as is' – this was a liberating recognition that I'm glad to have had so 'early' in my research.

**Figure 1 Research Journal entry excerpt dated 18th November 2017**

The author was able to be critical of the data and of the meanings obtained therein and to question the process of collecting meanings into constituents to 'test' if these were reflective of the midwives' descriptions or products of her own thoughts. This reflexivity facilitated the necessary process of phenomenological reduction in ensuring that the essences of the phenomenon described by the midwives was actually apparent in the midwives' descriptions – a way of 'returning to the things themselves'

which is a significant component of Husserl's phenomenological process (Finlay, 2013). The reflexivity facilitated through journaling and meeting regularly with members of the research supervision team had the effect of reducing idiosyncratic thought and 'freeing' the researcher to adopt an openness to the research so central to the maintenance of the phenomenological attitude. The process of unburdening and bridling personal suppositions facilitated immersion in participant descriptions in a way that enabled "empathic listening" (Finlay, 2013, p. 9) or an "attentive being-with" (Todres, 2007, p. 80) that allowed the researcher to step into the dynamic life-world or lived experiences of the midwives which is a crucial component of phenomenological epoché (Bondas, 2011; Finlay, 2013; Giorgi, 2009). Having provided an overview of research paradigms as well as the methodology selected for this study, the next section of this chapter will address the research methods utilised.

## Methods

Research methods describe the process of "... data collection, analysis and interpretation" used to conduct a study (Creswell, 2018, p. 42). The role of the previously described research methodology is to provide an underpinning theoretical or philosophical framework for these techniques or methods of undertaking the study (Polit & Beck, 2014). There are several methods of descriptive phenomenological research, including those offered by Giorgi, Colaizzi and Van Kaam (Polit & Beck, 2014). There are broad similarities between each of the previously mentioned methods (Polit & Beck, 2014) however Giorgi's method for phenomenological data analysis was selected as it offers one of the earlier frameworks for a 'scientific' approach to the analysis of phenomenological research grounded in the philosophy of phenomenology (Giorgi, 1997, 2005, 2009). Giorgi describes in detail the differences between the philosophical and scientific methods and emphasises the importance of holding in abeyance the researcher's own consciousness; the necessity of adopting the phenomenological attitude; acknowledging that participant descriptions of phenomena are made on that which is 'present' to them; and the importance of disciplinary intuition for the transformation of descriptions into essences of the phenomenon (Giorgi, 1997).

It was considered that the way in which Giorgi described the process of articulating the (often complex) philosophy of Husserlian phenomenology with the suggested 'steps' or method of data analysis was presented in a coherent and accessible manner. In addition to this, Giorgi's description of the role of phenomenological reduction and adoption of the phenomenological attitude throughout the whole research process, not only during the data analysis phases demonstrated a consistency with the philosophy of phenomenology that was considered desirable. This next section will describe the process of conducting the research using Giorgi's method and make reference to the ways in which the guiding methodology of descriptive phenomenology has influenced the undertaking of the same.

## Design and Research Aim and Objectives

A descriptive phenomenological design was employed to address the research aim and objectives.

Aim

Explore Western Australian (WA) midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth

Objectives

1. Explore Western Australian midwives' perceptions of the phenomenon of being 'with woman'
2. Explore the lived experiences of being 'with woman' during labour and birth from the perspective of Western Australian midwives working in a range of practice contexts

## Sampling

Qualitative research utilises non-probability approaches to sampling which facilitate the intentional and non-random selection of participants who have knowledge and or experience of the phenomenon under study (Richardson-Tench, Nicholson, Taylor,

Kermode, & Roberts, 2018). The inclusion criteria for this study required that participants had to be registered midwives either currently working in a labour and birth setting, or have provided labour and birth care within the past 12 months. These criteria were established to ensure that midwives' experiences allowed them to offer a contemporary description of the phenomenon in the context of the models of care currently represented in WA.

This study utilised purposive sampling, a popular strategy for phenomenological studies as it facilitates selection of participants based on their ability to share their knowledge and experience of the phenomenon under study (Giorgi, 1997; Polit & Beck, 2014). Because of the aforementioned importance of the woman-midwife partnership or relationship, it was considered important to collect data from all of the models of care available in accordance with the intention of the model to provide care by a known or unknown midwife. This study made no assumptions about the importance or otherwise of the relationship; but considered that relationship was a component of being with woman and ensured that this could be sufficiently described and uncovered in the design of this research. Initially, the opportunity to participate in the research was presented at a local midwifery conference attended by over 170 midwives. Here, nine midwives working in a variety of models indicated their interest in participating. These midwives provided contact details and an information and consent form was emailed to them. This provided the opportunity for midwives to carefully consider participation in the study without having to 'commit on the spot'. Each of the midwives agreed to be interviewed. From this point, snowball sampling was utilised where the 'purposefully sampled' participants connected the researcher to other potential participants. Snowball sampling, also known as network or chain – referral sampling is an accepted sampling method and often used in conjunction with purposive sampling (Whitehead & Whitehead, 2016).

There is no set formula for determining the 'required' sample size within qualitative studies. For phenomenological research, Creswell (2018) recommends a sample size of between three and ten participants; Cleary, Horsfall, and Hayter (2014) suggest that a sample size of up to 20 is not uncommon, Polkinghorne (1989) mentions that

anywhere between 5 to 25 participants might be interviewed and Cypress (2018) suggests interviews with between 3 and 30 participants. Giorgi (2009) maintains that the sample size is of less importance than the richness of description; and that there needs to be sufficient participants to identify a range of variation and recommends a sample size of at least three. There is agreement among phenomenological and other qualitative researchers that the final sample size is determined by achieving rich and saturated descriptions of the phenomenon under study; and that when participant descriptions are being repeated with no new concepts introduced, interviewing may cease (Creswell, 2018; Fusch & Ness, 2015; Giorgi, 1997; Polit & Beck, 2014; Sandelowski, 1995; Whitehead et al., 2016a)

A conservative approach to sampling was adopted in this study, it was not pre-determined how many midwives overall would need to be recruited, or if recruitment would need to be based on the various models that midwives worked in. Maintenance of an 'open posture' to the data was important, as such there was no pre-determined agenda to separate out the reporting of any of the aims of the research. Instead, midwives were recruited as they presented regardless of the model they were employed in. It was not possible to determine if the phenomenon of being 'with woman' would be perceived and described similarly by all participants, or, if the experiences of being 'with woman' within the context of the particular model worked in would be similar or different. Further detail on the data analysis strategy is referred to later on in this chapter but a constant 'checking' in with the data during collection was conducted. What became apparent after four interviews with midwives working in each of the three models was that the phenomenon of being 'with woman' was perceived, and understood similarly by midwives. What was noteworthy however was the way the phenomenon was experienced in the context of each of the models was different. Therefore, a decision was made to recruit until richness within the data was achieved from the standpoint of the experiences of being 'with woman' in the context of each of the models (see Table 1 - Chapter 1) explaining the three different models of care. A full decision trail regarding the handling of the data is discussed in later sections (Figure 3).

In total, 31 midwives participated in this study; their ages ranged from 35 to 62 years and they had between 3 and 35 years of midwifery experience. Ten midwives worked in midwifery continuity models where labour and birth care is provided by a 'Known Midwife' (KM) ; 11 were from private obstetric-led models where care is provided by an 'Unknown Midwife and Known Obstetrician' (UMKO); and a further 10 worked in models where care is provided by midwives not previously known by the women, or, 'Unknown Midwives' (UM). Participants had a variety of midwifery education levels and experiences working as a midwife in other countries around the world. Of the 31 midwives interviewed, 22 had experience working in at least one alternate model which was different to the one they were currently employed in. A comprehensive demographic profile of all of the midwives interviewed in this study according to model of care is presented in Table 1.

**Table 1 Demographic profile of all participants and participants according to model of care**

| Demographic variables | Participant numbers N=31 | Midwives in Known Midwife (KM) Model N=10 | Midwives in Unknown Midwife Known Obstetrician (UMKO) Model N= 11 | Midwives in Unknown Midwife (UM) Model N= 10 |
|---|---|---|---|---|
| Gender | | | | |
| Female | 31 | 10 | 11 | 10 |
| Age | | | | |
| 30 to 40 | 9 | 2 | 5 | 2 |
| 41 to 50 | 9 | 5 | 2 | 2 |
| 51 to 60 | 12 | 3 | 4 | 5 |
| 61 to 70 | 1 | 0 | 0 | 1 |
| Years of experience as a midwife | | | | |
| < 5 years | 3 | 1 | 2 | 0 |
| 5 to 10 years | 8 | 3 | 3 | 2 |
| 11 to 15 | 6 | 3 | 2 | 1 |
| 16 to 20 | 1 | 0 | 0 | 1 |
| 21 to 25 | 2 | 1 | 0 | 1 |
| 26 to 30 | 7 | 1 | 2 | 4 |
| 31 to 35 | 4 | 1 | 2 | 1 |
| Level of midwifery education | | | | |
| Hospital–based diploma | 12 | 3 | 4 | 5 |
| Undergraduate midwifery degree | 6 | 3 | 2 | 1 |
| Postgraduate midwifery qualification | 13 | 4 | 5 | 4 |
| Other countries practiced midwifery aside from Australia | | | | |
| England | 4 | 1 | 1 | 2 |
| Scotland | 1 | 0 | 0 | 1 |
| New Zealand | 2 | 1 | 0 | 1 |
| Previous Experience in Alternate Model? | | | | |
| Yes | 22 | 10 | 6 | 6 |
| No | 9 | 0 | 5 | 4 |
| TOTAL | 31 | 10 | 11 | 10 |

## Data Collection

Data collection in phenomenological research is often conducted using in-depth interviews that utilise 'broad and open-ended questions' to encourage extensive description by the participants (Bevan, 2014; Giorgi, 1997). Fundamental to the process of interviewing in the descriptive phenomenological method is the concept of adopting a phenomenological attitude which requires the researcher to suspend their own thoughts and perceptions and maintain a 'deliberate naïveté' to the phenomenon under study (Finlay, 2013).  Giorgi (1997) describes the process of interviewing where participants may be asked to describe the phenomenon in the first instance and then proceed to offer experiences of the phenomenon; this approach was adopted in the current study.

Data collection in this study was conducted through in-depth, semi-structured, one-to-one interviews lasting between 45 and 90 minutes. An interview guide was developed and used to broadly scaffold the questions asked to participants (Figure 2).

Key interview questions

- Please would you describe your perception of what it means to be ‘with woman’?
- Please would you describe your experiences of being ‘with woman’ in the context of the model you’re currently working in?

Optional prompt questions as needed

- Please explain what has influenced or shaped your view and practice of ‘with woman’ care during labour and birth?
- How does the model of care or practice context that you work in affect/impact you being ‘with woman’ during labour and birth?
- Is there anything in your current model of care or practice context that might enable you to be ‘with woman’?
- Is there anything in your current model of care or practice context that might offer a challenge you to being ‘with woman’?

If midwife has worked in other models...

I see that you’ve worked in another model of midwifery care previously – can you tell me, is your experience of being “with woman” different from that which you’ve experienced previously? How? Why?

Finally, do you have any questions for me?

Thank you for agreeing to participate in this research, your responses and time are very much appreciated.

**Figure 2. Interview guide with key questions and optional prompt questions**

Interviews were conducted at a time and location that was convenient to the participants. Being shift workers, many midwives requested to meet in their homes, some preferred to meet in an interview room in their place of work. Data were collected concurrently from midwives working in all models over a period of nine months. A timeline of research activities is displayed in (Appendix C). The majority of

interviews were face to face, however, four interviews were conducted over the telephone to facilitate the inclusion of midwives working in rural areas. All interviews were digitally recorded with permission and transcribed verbatim. The first two interviews were transcribed by the researcher facilitated by the use of Speech to Text software which provided useful insight into interview techniques and the transcription process. In order to best utilise research time and facilitate the timely completion of transcription, a professional research-specific transcription service was then employed to undertake transcription of the remaining 29 interviews. The transcriber was required to provide assurance of confidentiality (Appendix D)

Adopting a phenomenological attitude was essential and facilitated a posture of 'deliberate naiveté' towards the phenomenon (Bevan, 2014; Finlay, 2009). This previously described suspension of the natural attitude enabled the researcher to be fully present and follow the accounts of the participants which prompted subsequent questions during the interview to clarify or elucidate the descriptions offered by midwives. As noted in Figure 2 the opening question was "Please would you describe your perception of what it means to be with woman?" Midwives typically offered an answer that was a sentence or two; invariably this was quickly followed by an assertion that 'it' (being 'with woman') was 'difficult to describe'. Midwives were then asked to describe their experiences of being 'with woman' which midwives responded to with 'I would make sure I _____', 'I would always do _____'. Realising that these were descriptions of intentions rather than experiences, the question was reframed to something that might be more understandable. "If I (researcher) was a fly on the wall and I was to see you being 'with woman' – what would I notice or see/ what would I not see; from that, can you describe your experiences of being 'with' a woman?" This prompt was beneficial and midwives were then able to describe often several experiences of being 'with woman' including all of the identifying features that were present. In so doing, midwives offered descriptions of the phenomenon from all 'angles', including what being 'with woman' was and what it wasn't (Finlay, 2013).

The second line of questioning followed to gain an understanding of the phenomenon in the context in which the midwives worked. The question asked was "please describe

your experiences of being 'with woman' in the context of the model you're currently working in?" This was followed with an opportunity for midwives to reflect on any factors inherent to the model that might intersect on being 'with woman'. Midwives who had worked in different models previously were also offered the opportunity to describe experiences of being 'with woman' in the context of those models. Midwives often spontaneously described different experiences of being 'with woman' in alternate models as a way of qualifying what elements were inherent and unique to their current model. This served to differentiate the factors unique to each model that intersect with the phenomenon of being 'with woman' and to confirm the descriptions specific to each model the midwives were currently working in.

## Data analysis

The following section describes how the stages of Giorgi's phenomenological method was applied to analysis of data. To enhance clarity, the stages are presented in a sequential order here (Appendix C), however the analysis occurred in a less linear manner interweaving between each stage as required (Finlay, 2013; Giorgi, 1997, 2009).

Due to the interlinking process of data analysis, Giorgi's stages commence with an early adoption of the phenomenological attitude which is described as suspension of the researcher's natural attitude and adopting an openness toward the phenomenon under study. This facilitates the researcher to acknowledge and hold in abeyance previous assumptions and knowledge about the phenomenon to avoid personal preconceptions influencing the process of data collection and analysis (Giorgi, 1997). Other elements of the phenomenological attitude previously discussed include reflexivity which encourages critical self-dialogue and active listening. Each of these elements phenomenological attitude, reflexivity and active listening facilitate the researcher to approach the phenomenon with a 'deliberate naiveté' and allow the researcher to connect with how the phenomenon is revealed to the participants (Bevan, 2014).

### Reading of the data

In this initial stage, transcripts were read and re-read in order to gain a global sense of the data. Giorgi (1997) maintains that the purpose here is not to begin to search for themes or concepts but to gain a sense of the data as a whole in preparation for the next stage. In the first reading, transcripts were read through whilst listening back to the audio to ensure accuracy of transcription. Being mindful to adopt the phenomenological attitude, transcripts were then read several more times each while listening to the interview audio which facilitated a total immersion in the participants' descriptions and enabled an overall sense of the data.

### Dividing the data into parts

In this next stage, the data is re-read with an attitude orientated to discovery (Giorgi, 2009). The phenomenological attitude is maintained and the purpose of this stage is to discover 'meaning units' which are individual expressions of meaning attributed to the phenomenon. It is recommended here that "professional sensitivity and spontaneity" is allowed to function which incorporates both the intuition of researcher and mindfulness of the research objective (Giorgi, 1997, p. 247).

The large amounts of qualitative data in this study were managed using qualitative data software Nvivo 11. The use of software to store, locate and facilitate coding of data is supported as an efficient means of data management over manual methods (Creswell, 2018). A fresh 'meaning' folder was created for each of the participants. In this stage, transcripts were read again in their entirety and meaning units were highlighted and given their own meaning label. A discrete meaning unit was established when it was observed that a change in the meaning had occurred within the interview transcript. The meaning units from each participant were considered and grouped according to their similar meanings, ensuring that each accurately represented the original description (Giorgi, 1985).

### Organisation and expression of the data

In this stage, statements from the research participants are transformed through the process of free imaginative variation wherein the researcher utilises ‘disciplinary intuition’ to consider how the individual meaning units might represent similar or divergent concepts (Giorgi, 1997). Giorgi (1985, 1997) describes this step as the most challenging in the data transformation process, considering requirement to simultaneously adopt a phenomenological attitude and employ disciplinary sensitivity. In this study, the aforementioned meaning units were grouped according to similar or divergent groups of meaning concerning the perceptions and experiences of being ‘with woman’. This was performed concurrently by the researcher and at least one other supervisor. Meetings were held to facilitate discussion about the organisation and grouping of meaning units to achieve agreement which enhances the dependability of the research findings.

### Expressing the structure of the phenomenon

The objective in this final stage is to determine the structure of the phenomenon, considering the constituents of the participants’ experiences and the meaning attributed to these. In this study, the constituents of the phenomenon of being ‘with woman’ were determined by viewing all of the meaning units offered by the participants. Through the use of imaginative variation, rather than ‘natural cognition’(Giorgi, 1985), meaning units that revealed similar constructs of the phenomenon formed constituents which were combined under an overarching theme (Giorgi, 1985, 1997; Moustakas, 1994). In this way, the necessary and invariant features commonly called ‘essences’ of the phenomenon are revealed (Cypress, 2018; Denzin & Lincoln, 2018; Giorgi, 1997). The aim of expressing the essences of the phenomenon is not to produce theory or definition (Giorgi, 1997, 2012) but to reveal a connected sense for the reader of what it is like to experience (in this study) being ‘with woman’ (Finlay, 2013; Moustakas, 1994).

## Decision Trail

To offer clarity around the decisions that were made in relation to the analysis of the data, a decision trail was formulated (Koch, 2006) (Figure 3). The decision trail serves to offer transparency and enhance the reproducibility of this study which contributes to the rigor of this research (Polit & Beck, 2014) and also clearly demonstrates the specific application of Giorgi's data analysis method.

Because the descriptions of being 'with woman' in the context of each model revealed such disparate and distinct experiences, the data which pertained to this were analysed separately according to each model. Rich descriptions of the factors which were unique to each model that intersected with the phenomenon to enhance or challenge the experience of being 'with woman' were revealed. Whereas midwives working in all of the models described their perception of what it means to be 'with woman', offering descriptions of the phenomenon as it appeared to them, which revealed strong congruence and was therefore analysed as a whole (Figure 3).

The next section of this chapter will address the trustworthiness of this study, considering each of the elements that add to the rigor of the research.

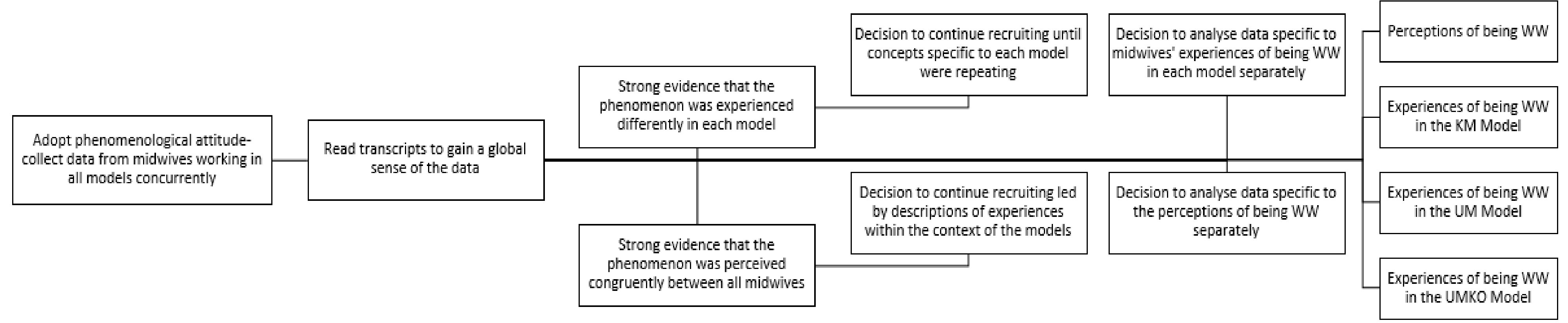


**Figure 3 Decision Trail**

## Research Rigor

Considerable debate exists about the criteria that should be used for the assessment of the 'truth value' in qualitative research (Polit & Beck, 2014). Researchers adhering to interprevist research paradigms, using methodologies such as phenomenology offer challenge to the belief in the "totality of knowledge" inherent in the 'modern' methodologies citing their "...obsession with prediction and control, quest for certainty, distrust of subjectivity and desire to displace personal judgement with quantitative rules..." (Bochner, 2018, p. 362). Even Giorgi has contributed to the discourse by suggesting that the search for external validity in phenomenological research "... is not as pressing as is often supposed" (Giorgi, 2002, p. 1). More recently, the search for the 'ultimate' framework to assess validity in qualitative research has seen offerings from numerous authors (El Hussein, Jakubec, & Osuji, 2016; Morse, 2015; Rettke et al., 2018). Others warn about the false sense of assurance that may be provided by the 'box ticking' exercise of appraising research quality merely through standardised frameworks for assessment (Flemming, Booth, Hannes, Cargo, & Noyes, 2018).

Despite the debate and dialogue over the necessity of, and best framework for trustworthiness assessment in qualitative research, it is widely recommended that one or more strategies or criteria are employed to demonstrate rigor in research (Creswell, 2018; Polit & Beck, 2014) . Indeed, the popular and well-known tools for assessing and reviewing indicators of quality within qualitative research, the Standards for Reporting Qualitative Research (SRQR) (O'Brien, Harris, Beckman, Reed, & Cook, 2014); and the Consolidated Criteria for Reporting Qualitative Research (CORE Q) (Tong, Sainsbury, & Craig, 2007) contain multiple trustworthiness indicators including auditability, credibility and triangulation. It is suggested that criteria designed to enhance reliability and trustworthiness are useful to ensure that the outcomes of qualitative research reflect "... the true state of human experience" and;  that the criteria offered by Lincoln and Guba (1985) are currently considered the "...gold standard for qualitative researchers..." (Polit & Beck, 2014, p. 332). Widely cited research authors Lincoln and Guba (1985) suggest four criteria for founding the trustworthiness of qualitative

research, these include: credibility, dependability, confirmability and transferability. These criteria are discussed in reference to this current study below.

*Credibility* speaks to the reliability of the truthfulness of the data, and the analysis of the same. Some factors that might enhance credibility are offered by Lincoln and Guba (1985) and include 1. Prolonged engagement and persistent observation; 2. Triangulation; 3. External checks; 4. Searching for disconfirming evidence; and 4. Researcher credibility.

*Prolonged engagement* was achieved in the research as the primary researcher conducted all interviews over a period of 9 months, utilising strategies such as digital recording which facilitated a sense of 'ease' of not having to record every detail, and allowed the researcher to become immersed in the descriptions offered by participants. This approach enabled the researcher to follow the descriptions of the participants which allowed a more full and complete revelation of the phenomenon under study through the intense and undistracted focus. The average length of each interview was 80 minutes which allowed the time required for participants to develop an ease which facilitated rich descriptions about the phenomenon of being 'with woman' accounting multiple experiences to describe the same. The transcripts were read-back while listening to the interview audio to ensure accuracy which further enhanced immersion within the data; then the steps unique to Giorgi's method previously described enabled the 'prolonged engagement' with the data, which at each juncture facilitated observation of the factors unique to the phenomenon of being 'with woman' and the experience of the phenomenon in the various contexts of the participants.

*Triangulation* enhances credibility by drawing on multiple points of reference to indicate the trustworthiness of the data (Cypress, 2018). In this study, data source triangulation (Polit & Beck, 2014) was achieved through the inclusion of midwives working in the full range of settings and incorporating responses from all models of midwifery care currently operating within WA. Doing so, meant that a comprehensive perspective was achieved both on the understanding of the phenomenon of being

'with woman' as well as how this was experienced within the variety of settings(Giorgi, 2009). Investigator triangulation (Polit & Beck, 2014) was also achieved, each transcript was analysed by the primary researcher, and also concurrently by at least one other member of the research supervision team which enhanced the reliability of the findings. The research supervision team comprised of a Professor of Midwifery with 28 years' experience in qualitative research, and two Associate Professors, one of whom was a nurse and a midwife with 20 years' experience in qualitative research and the other a nurse with 11 years' experience in qualitative and mixed methods research.

The *external check* strategy utilised in this research was 'peer debriefing', in this method the researcher met with objective peers to review elements of the inquiry (Lincoln & Guba, 1985). On each occasion, peers were highly experienced midwife academics who were able to listen and ask further questions to provoke new thought and differing perspective. Features of the discussions were recorded in the research journal and discussed with the research supervision team. A research journal excerpt following one of these conversations is presented in Fig 4.

ACM Conference October 2017

Whilst attending the conference, I was pleased to have the opportunity to meet two international midwifery leaders who have profoundly influenced my midwifery and the desire to do this research. Both were very generous and allowed me to discuss some of the ideas coming out of our research so far. Specifically, it was useful to share that our research was showing that being woman-centred was a part of being 'with woman' and to hear their thoughts on this given that they have written widely both about being 'with woman' and the importance of providing care that is woman-centred. To get a sense of the articulation and relatedness of providing care that is woman-centred and being 'with woman' (that one is part of the other) was useful. They offered confirmation of the connectedness and relationship between providing care that is woman- centred forming part of the whole of phenomenon of being 'with woman'.

**Figure 4. Research Journal Excerpt – conversation with senior midwife**

Other phenomenological methods utilise the measure of 'member checking' (Finlay, 2009). Member checking is not a feature of Giorgi's method who maintains that participants cannot be expected to adopt or maintain a phenomenological attitude which is key to the process of data analysis (Finlay, 2009; Giorgi, 2006). Rather, Giorgi maintains that findings should be distributed for critique, review and acceptance by the professional and scholarly community as the knowledge generated in phenomenological research "... is for the discipline not the individuals" (Giorgi, 2006, p. 358). Distribution of findings in this research has commenced through presentation at professional conferences and through the publication of findings in high-impact peer reviewed journals as documented in the Publications, Presentations and Awards in the front-matter of this thesis. The research has been received positively with commendation for the attention to methodological rigour (Mark Liveris Seminar, 2018) and usefulness of the findings (ACM, 2018).

Searching for *disconfirming evidence* is a strategy that enhances credibility by seeking to obtain potentially conflicting descriptions of a phenomenon (Lincoln & Guba, 1985). The broad sampling techniques utilised in this study facilitated the inclusion of midwives working in every maternity model in WA, doing this, opened up the possibility that varying descriptions could be obtained thereby achieving a comprehensive description. In addition to describing the features of the phenomenon of being 'with woman', participants were offered the opportunity to describe opposite characteristics thereby qualifying both what the phenomenon was and was not, again, adding to the all-inclusive review and description of the phenomenon under study.

*Researcher credibility* considers the fact that researchers are the instruments of data collection and apply the analytic processes that are required to develop findings of the research (Lincoln & Guba, 1985; Polit & Beck, 2014). The trust that can be placed in the researcher for this study is determined by the author's description of self, found in the introduction to this thesis and under reflexivity and reduction section of this chapter. The comprehensive description of the research supervision team found under the descriptions of triangulation also satisfies the criteria of researcher credibility as it endorses the research supervision provided to this study. Inherent in the methodology

of descriptive phenomenology is the important process of 'management of self' (Finlay, 2008; Giorgi, 2009) facilitated by adopting the phenomenological attitude which has been previously described in this chapter under the heading of reflexivity and reduction. Importantly, this posture is maintained throughout the data collection, analysis and reporting process (Giorgi, 1997). These features inherent in the phenomenological method intrinsically strengthen and offer rigor to findings generated (Berndtsson, Claesson, Friberg, & Öhlén, 2007; Bevan, 2014) . Other factors such as the maintenance of a research journal and regular meetings facilitated the bracketing and reflexivity required to undertake phenomenological research in a way that is consistent with the philosophical origins of the methodology which enhances rigor (Bondas, 2011; Ortlipp, 2008).

The second construct of *dependability* refers to the reliability of "data stability" over time and under a variety circumstances (Polit & Beck, 2014, p. 335). Dependability is often considered mutually contingent on the credibility of the research (Lincoln & Guba, 1985). In this study, dependability was achieved through the 'split-half' technique where the primary researcher analysed each transcript which was also simultaneously and concurrently analysed by at least one other member of the research team. Team meetings were held to discuss constructs and thematic appearances, any variation in discoveries were addressed by returning to the original data until consensus between members of the research team concerning final themes was reached.

*Confirmability* refers to the objectivity of data handling and is enhanced by the use of an audit or decision trail (Morse, 2015). In this study, a decision trail was used to demonstrate the process of data collection and data analysis, to convey the appearance of themes and make clear, the rationale for certain decisions made. These are described throughout the data analysis section of this chapter and explicated in the Figure 3. Participant quotes are also used to support the interpretation and presentation of findings of this research (Giorgi, 1997).

*Transferability* considers the ability of research findings to be applied to different settings or groups of people and is determined by the reader (Creswell, 2018). In this study, transferability is facilitated through the rich description of the phenomenon under study from the perspective of midwives working in different models of care. In addition to this, description of midwives' experiences of the phenomenon in the context of all of the maternity settings within WA provides a rich, thorough and reliable understanding of the phenomenon. In-depth explanations of each of the research settings as well as the demographic data of the participants provides a thorough understanding of the participants and places involved in this research which enables the reader to consider the transferability of the findings of this research to their own setting.

## Ethical Considerations

The conduct of research in Australia is governed by the National Statement on Ethical Conduct in Research 2007 (updated 2018) and the Australian Code for the Responsible Conduct of Research 2007 in accordance with the National Health and Medical Research Council Act 1992. In addition, research conducted at Curtin University must also adhere to the Guidelines for Human Research Ethics. Once enrolled as a doctoral student, the researcher was required to undertake research integrity training prior to Candidacy approval. Part of the doctoral candidacy process required an application to the University's Human Research Ethics Committee at Curtin University. The study was approved by Curtin University Human Research Ethics Committee (HREC) (HREC 2016 - 0450) on 10th November 2017 (Appendix E).

Prospective participants were provided with an information form which outlined the purpose, benefits and requirements of participating as well as the right to withdraw from the study at any time (Richardson-Tench et al., 2018) (see Appendix F). Written consent was obtained from those who chose to participate in the research (Appendix G) (Fuller & Schneider, 2016). There was no expected cost or foreseen potential for duress to participants however midwives were reminded of the ability to access free and confidential counselling through their employee access program: none became

distressed during interviews or disclosed the need to access counselling. In fact, the opposite was reported where midwives relayed their appreciation for the opportunity to discuss and realise their professional philosophy which was integral and central to their practise.

Research data were handled in accordance with the Australian Code for the Responsible Conduct of Research, Curtin University's Records and Information Management Policy, Research Data and Primary Materials Policy and Research Management Policy. Digital recordings of the interviews were transcribed verbatim, used to check accuracy of the transcription and to facilitate data immersion, after which they were deleted. Transcript files were allocated a code according to the model of care the midwife worked in and the date of the interview which was assigned as the file name and then linked to the participant on a separate spreadsheet stored on the encrypted and password protected Curtin University R drive which is a research-dedicated, password-protected secure, online repository only accessible by the researcher and the principal supervisor (Polit & Beck, 2014). A password and Curtin University firewall-protected laptop computer was used to work with the Nvivo software to manage the large volumes of qualitative data. Once coding had been completed, all Nvivo files were transferred to the University R Drive and deleted from the laptop. All hard data including signed consent forms were stored in a locked drawer in the researcher's locked University office. Upon completion of this study, hard and electronic data will be archived at the University for seven years after which time it will be destroyed in accordance with the National requirements (National, Australian Research Council, & Universities Australia, 2007).

## Chapter Conclusion

This chapter has described the role of research paradigms, methodology and methods highlighting the significance of each as it applied to the conduct of this study. The research paradigm and methodology along with the founding philosophy has been

described as well as clarification of the application of Giorgi's method to this study. Constructs enhancing research reliability and ethical considerations have been outlined. The following chapter presents the first set of findings of this study reporting on midwives' perceptions of the meaning of being 'with woman'.

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# Chapter Four • Midwives' perceptions of being 'with woman'

## Chapter Introduction

This chapter presents the final manuscript of an article (currently under review). The manuscript addresses the study objective of exploring midwives' perceptions of the phenomenon of being 'with woman' during labour and birth. The findings present the first ever published understanding of how midwives perceive and conceptualise the phenomenon of being 'with woman' as revealed in their description of experiences. Midwives working in a variety of maternity settings and with disparate levels of experience and midwifery education revealed essences of the phenomenon described as central to the profession of midwifery, and identifying to the practise of midwifery. The importance of relationship with the woman was confirmed as being integral to being 'with woman' as was providing care that was inclusive of the woman's support people. Being 'with woman' required midwives to be woman-centred in their care which revealed a swathe of attributes that have previously been understood as 'good' midwifery practices – for the first time here, identified as belonging to the practice attributes of being 'with woman'.

The journal *BMC Pregnancy and Childbirth* was selected for this article as it holds one of the highest impact factors for the Field of Research of midwifery (Impact Factor 2.3 for 2017). This open access, international journal was selected as it facilitated the distribution of the important findings of this study regarding a phenomenon that has demonstrated significance to the profession of midwifery globally.

Reference

Bradfield, Z., Hauck, Y., Duggan, R. & Kelly, M. Midwives' perceptions of being 'with woman': a phenomenological study. **Currently under review**

Title: Midwives' perceptions of being 'with woman': a phenomenological study.

## Abstract

Background

Being 'with woman' is a central construct of the midwifery profession however, minimal research has been undertaken to explore the phenomenon from the perspective of midwives.

Aim

The aim of this study was to describe Western Australian midwives' perceptions of the phenomenon of being 'with woman' during the intrapartum period.

Method

Descriptive phenomenology was selected as the methodology for this study. Thirty one midwives working across a variety of care models participated in individual interviews. Giorgi's four stage phenomenological approach was employed to analyse data.

Results

Three themes were extracted 1) Essential to professional identity; 2) Partnership with women; and 3) Woman Centred Practice. Midwives described the importance of being 'with woman' to the work and identification of midwifery practice. Developing a connection with the woman and providing woman-centred care inclusive of the woman's support people was highlighted.

Conclusions

For the first time, we are able to offer evidence of how midwives understand and perceive the phenomenon of being 'with woman' which has theoretical and practical utility. Novel findings from this innovative study provide evidence that supports expert commentary and confirms that midwives conceptualise the phenomenon of being 'with woman' as essential to the identity and practise of the profession. Some previously identified 'good midwifery practices' were revealed as practical manifestations of the phenomenon. This new knowledge facilitates clarity and provides evidence to support statements of professional identity, which is useful for the development of educational curricula as well as supporting graduate and professional midwives. The findings emphasise the importance of the development of language around this important philosophical construct which permeates midwifery practice, enhances professional agency and supports the continued emphasis of being 'with woman' with new understanding of its applied practices in a variety of care models.

Keywords: 'with woman', midwifery, philosophy, phenomenology, professional identity

## Background

Being 'with woman' (WW) is a central tenet of midwifery philosophy and practice. Statements from peak midwifery professional bodies around the world reference the importance of working in partnership with women and providing care that is woman centred (ACM, 2004; ACNM, 2004; CAM, 2017; Guilliland, 2010; RCM, 2014). The Australian College of Midwives' professional philosophy statement reads "Midwife means 'with woman': this underpins midwifery's philosophy, work and relationships" (ACM, 2004, p. 1). This statement explicates the fundamental importance of being WW to the profession of midwifery. Australian professional practice standards highlight the importance of being WW to underpin the practise of midwifery (NMBA, 2006a, 2008, 2018) and the International Confederation of

Midwives also confirms the importance of being WW by working in partnership with women (ICM, 2014).

Despite the significance of being WW to the profession of midwifery there has been little research that has specifically focussed on the constructs or practice of being WW. One midwife academic from the United States (US), published a literature review as a precursor to her doctoral research that referenced studies exploring women's perceptions of 'good' midwifery care (Hunter, 2002). From the research describing women's perceptions and experiences of midwifery care, Hunter developed a set of characteristics that she asserts were attributable to being WW such as: "knowledge and professional expertise, sensitivity, personal attention, nurturance, support and guidance, advice and information, and; a trusting guide" (Hunter, 2002, p. 1). Hunter presented a hermeneutic phenomenological study of birth poetry written by ten midwives which revealed that being WW is a specific and unique component of midwifery care (Hunter, 2003). Later, Hunter (2009) conducted a descriptive correlational study that surveyed 238 low risk women who gave birth in a hospital or birth centre in the US and asked them to rate their experience of being 'with' their midwife using Lehrman's Positive Presence Index Scale. With the contention that therapeutic presence was an essential component of being WW, results confirmed that women who began or proceeded to birth in a birth centre environment rated higher presence scores than their standard hospital labour ward counterparts (Hunter, 2009).

A recent integrative review confirmed that the midwife-woman relationship characterised by inclusiveness, sensitivity and care is an important element of being WW (Bradfield, Duggan, et al., 2018). Australian research exploring the intersection of being WW in the context of the private obstetric model recently revealed that in that clinical context, the unique triad of relationships between the woman, midwife and obstetrician was an important feature that could facilitate and challenge midwives being WW (Bradfield, Kelly, et al., 2018).

Further research, not specifically aimed to explore the concept of being WW; but midwifery practice in general, serendipitously discovered constructs of being WW. Davis and Walker (2011) interviewed 48 case-loading New Zealand midwives to explore how these midwives constructed their care. The authors concluded that in being WW, midwives were able to provide woman-centred care that enabled women to move through a variety of maternity contexts and settings according to their individual needs (Davis & Walker, 2011). Furthermore, Barker's study (2010) reported on the analysis of interviews conducted with seven midwives from the United Kingdom (UK) that explored experiences of providing emotional support to women becoming mothers. Findings revealed that midwives face a dilemma between being 'with institution' and fulfilling the needs of the 'system' that manages healthcare services versus being WW (Barker, 2010).

Midwifery leaders from the UK, US and Australia have emphasised the importance of being WW to midwifery practice citing the historical context of WW practices. Authors heralded the professionalisation of midwifery in turn-of-the-century publications maintaining that being 'with woman' was an appropriate cornerstone for the development of professional philosophy (Fahy, 1998; Isherwood, 1992; Tritten, 2000). In recent times, being WW is offered as the antidote to the techno-rational medical model that problematizes women during childbearing and facilitates a woman-centred approach to enhance agency to women and midwives alike (Dabrowski, 2014).

The woman-midwife relationship has been asserted as a significant construct of being 'with woman' and is a widely reported feature in professional and editorial commentary (Crowther et al., 2016; Hunter, 2015; Kennedy et al., 2010; Page, 2003; Page, 2008) This knowledge provided by midwifery leaders provides the impetus to deliver an evidence-informed understanding of how and in what ways, the woman- midwife relationship forms part of being WW in the context of the various maternity settings that midwives work.

Despite the centrality of being WW to the thinking, theory, and practice of midwifery, a recent integrative review revealed there has been no research to date that has explicitly sought to explore or qualify this phenomenon from the perspective of midwives (Bradfield, Duggan, et al., 2018). Having an understanding of the constituents of the phenomenon of being WW from the perspective of midwives would offer a unique and important conceptualisation of this foundational professional philosophy. Considering the asserted centrality of the woman- midwife connection to the philosophy of being WW, as well as the identified gaps in knowledge, it was considered prudent to explore the understanding held by midwives working in a variety of settings. Consequently, the aim of this study was to explore midwives' perceptions revealed through experiences of the phenomenon of being WW in the intrapartum period. This research forms one component of a series of studies which; as well as describing midwives' perceptions of the phenomenon of being WW here, also included distinct components that sought to understand midwives' experiences of being WW in the context of the various models of maternity care within WA. Findings of the intersection of being WW in the context of the various models have been published elsewhere (Bradfield, Hauck, Kelly, & Duggan, 2019a; Bradfield, Hauck, Kelly, & Duggan, 2019b; Bradfield, Kelly, et al., 2018).

## Methods

This study used a descriptive phenomenological design to explore midwives' perceptions and experiences of being WW during labour and birth. Developed by Husserl, phenomenology has its genesis in the discipline of philosophy which involves the thoughtful and methodological exploration with a 'phenomenological attitude' and is useful to explore the 'way things appear' in relation to the way phenomena are experienced (Giorgi, 1997). Central to descriptive phenomenology is the adoption of a phenomenological attitude which is characterised by the researcher's openness toward the phenomenon under study. It is widely asserted that this methodology is useful to elicit rich descriptions from participants and reveals constituents of the same phenomenon as it is experienced by different

individuals (Finlay, 2013; Flood, 2010; Giorgi, 1997; Lopez & Willis, 2004; Matua, 2015). This stance was considered the ideal methodological approach given that little research has been conducted to specifically understand the phenomenon of being WW. Descriptive phenomenology is known to elucidate poorly understood aspects of phenomena from the perspective of the participants with lived experience, to share the distinct or essential features, which facilitates a general conception of the phenomenon (Bevan, 2014; Matua & Van Der Wal, 2015). It is asserted that the methodology is useful for revealing essences of a phenomenon in a way that "...neither adds nor subtracts from the invariant intentional object arrived at, but describes it precisely as it presents itself" (Giorgi, 2009, p. 137). Because of the sparse nature of any previous empirical research on this phenomenon, it was considered important to keep as close to the midwives' descriptions as possible which also guided the selection of this methodology. Amadeus Giorgi, a devotee of Husserl offered one of the earliest frameworks to structure the phases of phenomenological research, adding rigor and transparency; his approach is utilised in this research (Giorgi, 1997). This study was approved by Curtin University Human Research Ethics Committee (HREC) (approval number HREC 2016 - 0450).

## Participants

Midwives working in Western Australia (WA) who had provided labour and birth care to women in any setting within the previous 12 months were recruited. The research was set in WA which has a two-tiered system of public and private care; within these systems there are three main models of midwifery care, where care is provided by an unknown midwife (UM), an unknown midwife under the direction of a known obstetrician (UMKO) and finally; a known midwife (KM). These models are further explicated in Table 1.

**Table 1. Models of Midwifery Labour and Birth Care in Western Australia**

| | **Unknown Midwife (UM)** | **Unknown Midwife** Known **Obstetrician (UMKO)** | **Known Midwife (KM)** | | |
|---|---|---|---|---|---|
| | Public Obstetric-led Midwifery Care | Private Obstetric-led Midwifery Care | Public Midwifery Group Practice (MGP) | Public Community Midwifery Program (CMP) | Privately Practicing Midwife (PPM) |
| | Woman attends hospital where labour care is usually[1] provided by an **unknown midwife** | Woman attends hospital where labour care is provided by an **unknown midwife** managed by the woman's **known obstetrician** | Woman contacts her **known midwife** and prepares for birth in planned place | Woman contacts her **known midwife** and prepares for birth in planned place | Woman contacts her **known midwife** and prepares for birth in planned place |
| **Woman's Planned Place of Birth** | | | | | |
| **Public Hospital** | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Private Hospital** | | ✓ | | | |
| **Public Birth Centre** | | | ✓ | ✓ | |
| **Planned Home Birth** | | | ✓ | ✓ | ✓ |
| **Freestanding Birth Centre** | | | ✓ | ✓ | ✓ |

1 In some smaller rural or secondary public hospitals, it is possible that the midwife may provide antenatal care and serendipitously provide labour and birth care and so there may be opportunity for relationship, it is estimated that this would account for <1% women in this model.

Summarised data from WA Department of Health 'Having a Baby' (DOHWA, 2016)

The study was initially advertised at a local midwifery conference with over 170 midwives in attendance. Midwives were purposively sampled to ensure in-depth capture of the phenomenon and those who expressed interest in the study were contacted. Further recruitment occurred through the process of snowballing which was an effective strategy to connect the researcher to participants who had a lived experience of the phenomenon working in a variety of settings (Whitehead et al., 2016b) . Prospective participants were emailed an information letter and written, informed consent was obtained prior to interview. In total, 31 female midwives

participated; their ages ranged from 35 to 62 years and they had between 3 and 35 years of midwifery experience. Ten midwives worked in midwifery continuity models where labour and birth care is provided by a 'Known Midwife'; 11 were from private obstetric-led models where care is provided by an 'Unknown Midwife and Known Obstetrician'; and a further ten worked in standard public models where care is provided by midwives not previously known by the women, or, 'Unknown Midwives'. Participants had a variety of midwifery education levels; a comprehensive demographic profile is presented in Table 2.

**Table 2. Participant Demographic Profile (N= 31)**

| Demographic variables | Participant numbers |
|---|---|
| Gender | |
| Female | 31 |
| Age | |
| 30 to 40 | 9 |
| 41 to 50 | 9 |
| 51 to 60 | 12 |
| 61 to 70 | 1 |
| Years of experience as a midwife | |
| < 5 years | 3 |
| 5 to 10 years | 7 |
| 11 to 15 | 6 |
| 16 to 20 | 1 |
| 21 to 25 | 3 |
| 26 to 30 | 7 |
| 31 to 35 | 4 |
| Level of midwifery education | |
| Hospital–based diploma | 12 |
| Undergraduate midwifery degree | 6 |
| Postgraduate midwifery qualification | 13 |
| Other countries practiced midwifery aside from Australia | |
| England | 7 |
| Scotland | 1 |
| New Zealand | 1 |
| Current midwifery model | |
| Known Midwife (KM) | |
| Midwifery continuity models, 5 different metropolitan services (including private practice) | 8 |
| Midwifery continuity models, 2 different rural sites | 2 |
| Unknown Midwife Known Obstetrician (UMKO) | |
| Three different metropolitan private hospitals | 11 |
| Unknown Midwife (UM) | |
| Standard public care, 5 different metropolitan hospitals | 8 |
| Standard public care, 2 different rural sites | 2 |
| Previous Experience in Alternate Model? | |
| Yes | 22 |
| No | 9 |
| TOTAL | 31 |

## Data Collection

In depth, one-to-one interviews lasting between 45 and 90 minutes were conducted at a location and time convenient to the participants. Four midwives were interviewed over the telephone as they were based in rural areas; all interviews were digitally recorded and transcribed verbatim. Data were collected concurrently from midwives working in all models. Adopting a phenomenological attitude provoked a deliberate naiveté which enabled the researcher to follow the accounts of the participants; this provoked subsequent prompts or questions from the interviewer during the interview to further clarify and elucidate the descriptions offered. Participants were asked to describe their perceptions and experiences of being WW. Establishing constructs through the descriptions of hyletic characteristics of a phenomenon is central to descriptive phenomenology (Moustakas, 1994). The opening question was "Please would you describe your perception of what it means to be with woman?" Midwives initially offered a sentence answer and then immediately proceeded to explain that being WW was 'difficult to describe'. Interviewer prompts were offered and the strategy that elicited the rich descriptions was the following "If I (researcher) was a fly on the wall and I was to see you being WW what would I notice or see/ what would I not see; from that, can you describe your experiences of being WW?" It was then that midwives were able to describe their experiences of being WW, expounding what being WW 'does' or 'looks like'; describing the phenomenon from all 'angles' including what it was and what it wasn't.

The interviewer, a midwife academic, was known to two participants as past professional acquaintances. The potential for influence on participant responses was considered minimal as the researcher had worked clinically with only two of the midwives for a short period over five years ago. The process of bracketing is central to phenomenological research and involved suspension of any prior conceptualisations or personal assumptions about being WW; which facilitated immersion in the participants' 'lifeworld' through their descriptions of their lived experience of being WW (Berndtsson et al., 2007). The interviewer was mindful to

adopt a neutral body posture and tone of voice to avoid influencing participant responses (Bevan, 2014; Giorgi, 1997). Additional strategies to enhance phenomenological reduction included: recording of the first author's assumptions about being WW prior to data collection; maintenance of a research journal to reduce any pre-existing thoughts and to facilitate reflection after interviewing; writing field notes; and having regular meetings with the other members of the research team (Ortlipp, 2008). There is no pre-determined method for predicting the 'required' sample size within qualitative studies. Within phenomenological research there is differing assertions with suggestions of between 3 and 10 participants(Creswell, 2018), up to 20 participants(Cleary et al., 2014) and between 3 and 30 participants(Cypress, 2018) (Sandelowski, 1995). Giorgi (Giorgi) maintains that the sample size is of less importance than the richness of description; and that there needs to be sufficient participants to identify a range of variation. We anticipated a larger sample size as we invited midwives working with labouring women in different models of care. A cautious approach was taken with regard to recruitment, to ensure that any differences described from participants working in the various models would be captured (Sim, Saunders, Waterfield, & Kingstone, 2018).

## Data Analysis

Data analysis was iterative and was scaffolded by Giorgi's four stage phenomenological approach which included: 1) data immersion; digital recordings of the interviews allowed the primary researcher to be 'fully present' and follow the lead of the participants' descriptions during the interviews. Re-reading the interview transcripts and listening to the audio recordings also facilitated data immersion; 2) dividing data into concepts where individual meaning units or conceptualisations were extracted. Data analysis software N-Vivo (v.11) facilitated the grouping and management of the qualitative data; 3) organisation and transformation of the data; in this step, arrangement and expression of the data into commonalities of midwives' descriptions revealed the necessary and invariant features of the phenomenon; and finally; 4) expressing the constituents of the

phenomenon. In this final step, use of the researchers' 'disciplinary intuition' enabled statements to be transformed into concepts articulating the constituents of the phenomenon (Giorgi, 1997).

The constituents of the phenomenon were supported by participant quotations(Giorgi, 1997) which were italicised in text with a unique identification code indicating the participant number and model of care worked in (KM, UM, UMKO P 1 – 11): Known Midwife (KM), Unknown Midwife (UM) and Unknown Midwife/Known Obstetrician (UMKO). The themes and subthemes were represented across each of the models, which are supported by a selection of quotes that have been chosen to facilitate a succinct presentation of the findings. To enhance clarity and brevity, non-essential words were omitted within quotes and are indicated by an ellipsis (…). Words that have been added to provide conversational context are not italicised and indicated by square brackets [ ] (Whitehead et al., 2016b). The first author analysed all transcripts which were also analysed separately and concurrently by at least one other member of the research team. Initial findings were conferred in a research team meeting and discussed until consensus was reached around themes and sub-themes which added rigor to the data analysis (Whitehead et al., 2016b).

## Results

Through the in-depth interviews, midwives offered rich descriptions of the phenomenon of being WW that were supported with recounted experiences of being WW during labour and birth throughout their years of being a midwife. Although midwives  were asked to describe the phenomenon of being WW during the intrapartum period, midwives working in each of the models asserted that being WW was not restricted to the period of intrapartum care; rather, that being WW is an essential component of midwifery practice across the continuum: *…I absolutely do think that with woman is more than just an intrapartum* [phenomenon] *because then I support them to have a really good breastfeeding*

*experience and a great start to being a mum and a great start to being parents* (KMP6).

Midwives repeatedly reflected on the challenge of describing the phenomenon of being WW: ... *it is hard, it* [is] *really interesting when I've been thinking, how do you describe it? It's really difficult* (UMP2). One midwife offered some insights into the source of the challenge and referred to the practise-based nature of midwifery work: '*Cause you don't actually put it into words,* [you] *put it into action* (KMP6). This reveals the embedded nature of this philosophical construct to the practises of many midwives. Three main themes were evident from the data: 1) Essential to Professional Identity; 2) Partnership; 3) Woman Centred Practice. These along with respective subthemes or essences of the phenomenon are presented in Figure 1.

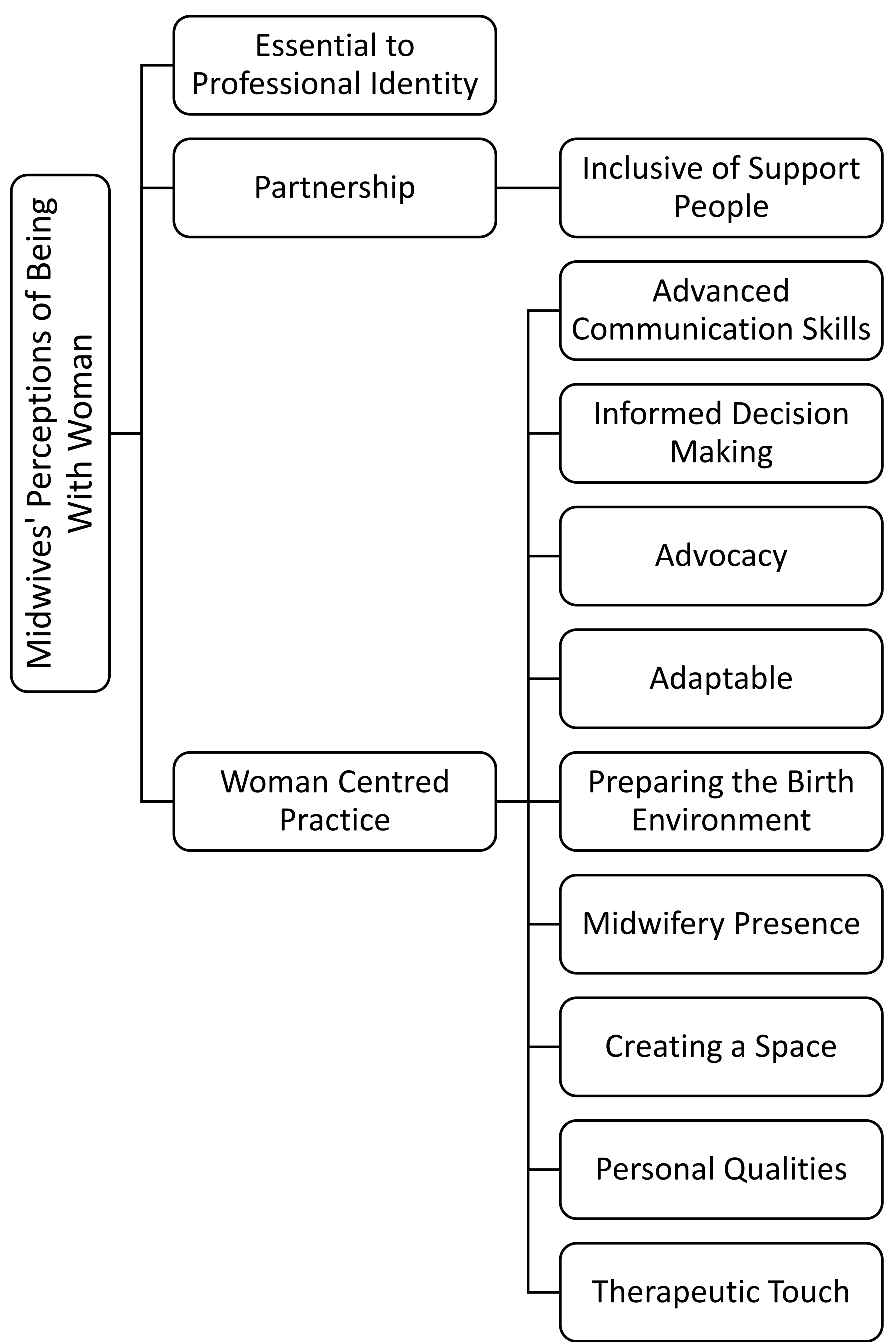


**Figure 1. Themes and subthemes. Midwives' perceptions of being 'with woman'**

### Essential to Professional Identity

Being WW was described as a necessary and integral feature of midwifery practice: *Yes it* [being WW] *is absolutely essential because without being 'with woman' you're not a midwife, you're just a person doing the job... that doesn't actually provide true midwifery care* (KMP9). The descriptions provided by midwives

confirmed that practise grounded in being WW is the identifying characteristic of midwifery care rather than the individual clinical tasks that midwives performed: *You couldn't do your job without being with woman, you have to be with woman...* [it's] *very, very important, that's the foundation... that is the primary role and then you start to do all the midwifery stuff* (UM P7). This stance was confirmed when midwives described experiences of working with midwives where tasks were performed without being WW: *It* [not being WW] *looks disconnected, it looks directed, she [the midwife] stands at a distance, she gives instruction from a distance. There's not a lot of eye contact, there's not a lot of engagement, there's not a lot of sincerity or warmth in that relationship or room or in that moment you know* (KMP6). Another midwife reflected: *You can provide midwifery care and not be 'with woman', you can be ticking your lists and checking your room but not actually being 'with woman'* (UMP6).

Midwives described that being WW was both fulfilling and satisfying: *It* [being WW] *is what I do it* [midwifery] *for, it's what I go to work every day for*... (KMP6). Midwives were cognisant of the privilege of being WW: *I just love it* [being WW] ... *it's a privileged job* [midwifery] *isn't it? I just love being part of it and, and empowering them* [women] (UMKOP7).

### Partnership

Midwives confirmed the importance of developing a connection with the woman which was often described as developing rapport, a partnership or, a professional relationship. Although this was manifested in different forms within the diverse models represented, each reinforced the importance of connecting with the woman in order to be WW. In the KM model, where midwives were able to offer continuity of care across the continuum, the descriptions were*: I'm in partnership with her… the family, the woman and the midwife and it's altogether* (KMP7). And from another midwife: *it* [being WW] *is built on a relationship of trust… Because you know them and because you've had time to develop the relationship and there's trust there because they will let you in more* (KMP10).

In the remaining two models where midwives provided labour care for women not previously known to them, the emphasis on building a connection with the woman was equally as strong with a focus on being effective: *I put a lot of effort into you know building that rapport and building that trust* (UMKOP11). One midwife offered strategies that she used to develop a quick connection with women she was caring for in labour: *So you have a tool kit that you use to develop your relationship with* [women] *by introducing who you are, what you do and ... you start to develop that relationship. And being with them, being at their bedside, being attentive to them and to their partners … we are sharing ourselves with each other so then that builds a relationship and trust* (UMP7).

Midwives also reflected on the challenge of developing connection with women who present in established labour but expressed the importance of the partnership that facilitated trust*: … that's hard, that building up that relationship. Again I think you've got to get her trust as quickly as you can … building up that trust and relationship really quickly but dealing with all the clinical stuff and showing that you know what you're talking about and ... what you're doing… showing a woman that you've got respect for her* (UMP5).

### Inclusive of support people

In addition to building a partnership with the woman, midwives were emphatic that being WW meant providing care that was inclusive of the woman's partner or support people: *So it's just getting that one on one relationship with her and her partner that's really important, and working together to get an agreed goal or outcome* (UMKOP10). Midwives shared strategies for encouraging partners to feel confident and important in the process of supporting the woman in labour: *Often you'll find that* [partners] *step back. I always say to them you know 'don't move out my way, come on I can get around you. She's number 1 in the room and you're number 2…you need to be where you need to be'. The women like their partners to be supportive, so you know that's kind of encouraging them to do what they need to do for their woman really* (KMP10). Midwives agreed that being respectful and

inclusive of the woman's partner or support people was important and further facilitated the partnership between the midwife and the woman: *… it is really important to include them in everything so that they can understand and feel 'part of the deal' because they're a very important person to that woman* (UMP4).

### Woman Centred Practice

In an effort to explicate the experiences or 'action' of being WW, midwives described the features of being WW as a way of embodying the practice elements of the phenomenon which revealed actions that signified midwives were being WW. Midwives were clear that this required practising with a woman-centred approach which demonstrated their ability to tailor care around what the woman wanted: *one of the first things I do when I look after a woman is,* [ask] *what does she want from me?* (UMP10). This required midwives to acknowledge the competing demands and agendas that may impact on the woman from other sources such as hospital policies and preferences of other practitioners and align themselves with the woman's agenda: *the woman is the centre and should remain the focus and the centre of your attention* (UMKOP1). Midwives in the continuity models described that providing care that is centred on what the woman wants is made easier by the strong relationship that has been forged:

working in a continuity model it's about knowing that woman what she wants in labour... being with woman I've had the opportunity to get to know her, to ask her the question and priorities for labour … so that when labour does happen, for me I don't have to ask her questions at that time it's more just about following her lead and knowing, already knowing what she wants to do and what her responses will be so there doesn't have to be any questioning in labour (KMP8).

Midwives working with women not previously known to them relied on their ability to build an effective partnership with the woman, and on birth plans which when supplied by the woman, helped midwives to quickly ascertain the woman's priorities in order to tailor her care: *listening to what she wants for her baby, for her birth, labour, if she's got a birth plan* (UMKOP6). In situations where a birth plan

was not formalised, midwives moved to open dialogue about how care could be adapted to meet the woman's needs:

If she doesn't have a birth plan I'll talk about what it is that she wants because I'm there to facilitate whatever it is that she wants from her birth experience and the only way I know that is by asking her what she wants... 'with woman' for me means always going back to the source, going back to the woman and seeing what it is that she wants from me (UMP10).

There were nine subthemes which constituted characteristics of providing woman centred care to demonstrate the practice of being WW which will now be described.

### Advanced communication skills

Possessing advanced communication skills facilitated midwives' ability to adopt a woman-centred approach and to be WW. Participants described the breadth of skills such as listening, hearing, clarifying, talking, providing verbal encouragement and the effective use of silence. As one midwife described: *Lots of listening to her and her partner and what their expectations are* (KMP5). Midwives reinforced that being open and listening to the woman further conveyed respect and developed trust between the woman and the midwife which facilitated partnership: *listening to her birth plan, her ideas, her fears, getting that trust* (UMKOP11). Midwives were able to provide insight into what an outsider might observe when they were practicing these skills: *So you would notice me looking at that woman, to see verbal and non-verbal responses, observing her, speaking slowly to her, softly to her, being sensitive to not trying to talk to her while she's … very obviously busy with her mind* (UMP8).

As well as listening to and hearing what is important to the woman, midwives reflected that they were also required to communicate with women in ways that were appropriate to different circumstances as shared by this midwife: *So I do talk a lot… through a contraction when they're challenged. I try to focus their* [women's]

*breath, their headspace and I find something about their strength or something about their breath or whatever I just continue to use that* (KMP6). Being WW included providing verbal encouragement: *just telling them they can do it* [birth] (UMP1). To be WW, midwives also used verbal encouragement to help women to reconcile unexpected outcomes during labour and birth: *encouraging them … that they're not a failure which a lot of women for some reason think that they are* (UMKOP9).

Midwives agreed that being WW sometimes called for silence, a pause in the rhythm of labour care that respected the woman's need for stillness to focus and re-centre herself: *Sometimes there'll be no communication, that might be being 'with woman'* (KMP8). There was a sense of being comfortable with the silence and using intuition developed in the respectful partnership to ascertain what the woman needed and wanted in that moment: S*ometimes you can have silence for a long time but … it's not an uncomfortable silence. Some women do go 'into themselves' and don't want a lot of chatter around them or touching or anything like that, but again reading that body language… some people change in labour so this would be being 'with woman'* (UMP5). Midwives emphasised the importance of holding the space and resisting the temptation to be 'busy', honouring the woman's need for silence: *…even if the room's dead silent we just sit there. We won't … go anywhere or do anything else we'll just sit there and be there, we don't get kind of distracted with "oh well I might go and restock theatre if nothing much has happened"* (UMKOP10).

### Informed decision making

Another way midwives were able to be woman-centred and demonstrate being WW was to spend time educating women to facilitate informed decision making: [the] *'with woman' thing is about them* [women] *having choice and them being the ones guiding what's happening for them... facilitating their decision making* (KMP6). There was a sense that in many cases this required midwives to create an environment that encouraged women to become powerful and utilise the agency

that is rightfully theirs: *it's about empowering the woman, supporting them to make decisions* (UMP7). Creating an environment where women were able to be autonomous and aware of their agency, required midwives to adopt a supportive role: *just being there and letting her make the decisions but supporting her through that process as well is really important* (UMKOP8). It was acknowledged that women might make decisions about their care that were different to the midwives' perceived 'right choice', which required a professional approach to respecting the woman's choice: *they've made a choice to come to this model of care and sometimes it's a choice that you don't always agree with ... but it's the woman's choice* (UMKOP7).

### Advocacy

Advocating for the woman was noted as an important manifestation of aligning with the woman's agenda and being WW. By understanding each woman and what she wanted, midwives were able to facilitate care:

... if something happens that goes off the path that she wanted and she hasn't got the power to say it because she's feeling vulnerable, she's feeling frightened, she's feeling embarrassed then it's your place to actually advocate for her ... people coming in and wanting ruptured membranes or to start antibiotics when the woman actually doesn't want antibiotics and she can't say it herself because she's too scared (KMP9).

Midwives reflected that 'stepping in the gap' and providing advocacy was often met with resistance from obstetricians or at times, other midwives. Being willing to tolerate any push-back or as this midwife describes it as, 'noise', was an important part of aligning with the woman's agenda: *...it's all about being with woman, being an advocate....* [midwives have] *to put up with the noise or the huffing and the puffing* (UMP4). It was clear that midwives understood the confidence required to advocate for women and were often aware that women valued this advocacy: *you have to be the advocate and really speak up and* [be] *confident doing that....*

*because the woman sometimes says things to you afterwards and says thanks for speaking up for me* (UMKOP8).

### Adaptable

Offering care that was woman-centred and focused on the woman's individual needs required midwives to be adaptable: *you need to consider people individually and adapt to that woman in that situation at that time* (UMP4). Being adaptable required self-awareness and was seen as a measure of strength and capacity: *I take pride in the fact that I can adjust and I can actually be what that woman wants me to be because I am reading her cues properly and appropriately and correctly and I can move between environments and I'm actually ok with that* (UMP8).

Midwives relayed how the ability to be adaptable develops with increasing experience and also allows midwives to adapt across a range of settings: *I adapt to the environment and to the women ... that is the beauty about being experienced is that you are adaptable* (UMKOP3). Midwives described the nuanced ways of 'reading' what a woman needed in the moment as well as determining what needs were being met by other support people: *based on where they're at, how they're coping, what they need and what they're getting from the other people that are in the room... I go by their behaviours, I go by what feedback they're giving me, visual feedback like how they're behaving ... they don't say much to you in labour, then I go by what I do, how they respond to that… which might be them softening into whatever I'm doing* (KMP8).

### Preparing the birth environment

Midwives also reported that preparing the physical environment or place for labour and birth according to the woman's needs was important to being WW:

… so they [women] would turn the lights off, they would go in and out of the bathroom, they would have music on... walking around and changing the furniture and leaning on stuff and you worked to what they did and if they weren't sure you could give them suggestions [so] it felt like their room (UMKOP5).

Another midwife describes what an outsider might observe: you would [notice] silence... not many lights, their music. Even if we are in labour in birth suite, they are silent, on a mattress, I push the bed on the side, put the mattress on the floor. Mattress, bean bag, shower (KMP7). Others described strategies to support privacy and normal birthing as a manifestation of being WW:

…trying to get them to find their own place in that horrible, stark, bright, noisy, non-natural birthing environment. So the bathroom's a good place I try and make that environment as conducive to normal birth as possible. So dimming lights, having quiet conversations and just rubbing her back or holding her hand or just sitting with my hand on her belly kind of timing contractions and listening to her voice, how she's coping with them (UMP3).

### Midwifery presence

Midwifery presence was asserted as a fundamental way of being WW that focused solely on the woman and offered in two parts, the first meant not leaving women to labour alone: *most of the time* [I am] *sitting by the woman, wherever she is I would be by her* (UMP7). There was agreement that the act of being physically present and focussed on the woman facilitated clinical assessment and care of the woman: ...*listen to the auscultation, have hands on palpation, rather than sit back and screen-watch... unless you're with them and can get the whole clinical picture then you can't really tell where they're at progress-wise* (UMKOP4). In being WW, midwives suggested their clinical care was improved: ...*being present I think you get a better clinical assessment because you are with woman* (UMP4).

The second part of being present was not simply about being in the room: *it means being present with her but I don't just mean present in the physical, but completely present* (KMP2). Midwives revealed that to an unaware observer, this might appear as though the midwife was 'doing nothing' and therefore the act of being present could be easy to miss and nuanced: *It's so easy to miss it and not realise it if you was watching me because it's done so quietly, it's done so non-intrusive* (KMP1). Another midwife confirmed this and added that whilst at times, being WW did

require 'action', midwifery presence was a valuable characteristic that often required a deliberate form of 'inaction': *well I can act if I need to but if I don't need to act or do anything then this* [being present] *is the thing to be doing now* (UMP9). Being present also meant engaging with and being available by being attentive, aware, empathic and noticing subtle changes in the woman's needs: *being present in the moment and making yourself available and open to whatever it is that she requires or needs to help her through* (UMP9).

### Creating a space

In being present and WW, midwives created and prepared a space for the woman to be in. Different to making accommodations in the physical environment, preparing the birth space referred to creating an atmosphere free from unnecessary interruptions, that was safe and private: *allowing that space and private time, without everyone walking through – not like a production line* UMP2. This assertion was supported by another who confirmed that being WW required midwives to create and protect the birth space and described potential protagonists for a labouring woman: *It is ensuring that birth remains sacred for her and that really she comes to no harm just by the other course of events or by other people coming in … friends, family, staff, organisation needs of interfering with the process of birth* (KMP3). A consequence of holding and protecting the space of labour was described as facilitating the physiology of labour, a practice unique to midwifery … *allows her body to work so the whole thing [labour] can move forward because you've just made this space… it's definitely unique to midwifery because there's no other situation where you're creating the space that will facilitate the outcome* (UMKOP9).

### Personal qualities

Being WW required midwives to provide sensitive care which involved essential characteristics such as kindness, gentleness and respect: *part of being 'with woman'… you care for women with kindness, with gentleness … with sensitivity, making sure that you treat those women as you want to be treated yourself. With*

*respect, with dignity, gentleness. I'm pretty big on gentleness* (UMP8). Or as another midwife shared: *…simple things about being nice to people… it's about actually being decent to people* (KMP3). Being kind demonstrated respect for women: *…respect is really important and they* [women] *will receive that respect really well and likely mirror that and you get trust from that person through that, through showing respect* (UMP4). Gentleness was also a way to demonstrate the respect inherent in being WW: *I'm just gentle with them* [women] *and appreciate them and respect them* (UMKOP8).

### Therapeutic touch

A final manifestation of being WW shared by midwives in their support of women involved use of therapeutic touch sensitive to the woman's needs: *being with woman you need to be able to touch her, to be able to calm her, massage, holding hands* (UMKOP6). Being self-aware and determining if the touch was therapeutic to the woman was essential:

I use touch a lot. So I'm a reflexologist … [I use] aromatherapy oils, I like touch , I get involved with massaging their back or getting the partner involved in touch as well which I think most women like at certain times. I ask them and go through it with them to help them feel a bit more comfortable (UMKOP8).

Midwives reflected on the impact of epidurals on the woman's need for physical support and therapeutic touch: if a woman is totally pain free she's not giving that body language that she would if she didn't have the epidural, there's not that need to go and touch her and rub her back and stuff... perhaps we've lost a bit of 'with woman' in that way (UMP5).

## Discussion

This study is the first to explicitly explore the phenomenon of being WW through in-depth interviews from the perspective of midwives providing intrapartum care in a range of maternity settings. Findings reveal the interconnectedness of this

philosophical construct and the practice of midwifery. By using a phenomenological lens to explore the experiences of being WW, midwives were able to offer rich descriptions of both the attributes that characterise the phenomenon as well as the way in which these are manifested through their practice of midwifery.

Our findings emphasised the importance of being WW to the identity and work of midwifery, such that midwives who were not displaying the characteristics and manifestations of the phenomenon were described as not 'doing' midwifery, or not 'being' midwives but merely persons providing care. The concept of midwives being 'with woman' rather than doing 'to women' has been previously explored where researchers have sought to identify the features of exemplary midwifery care (Kennedy, 2000); describe midwives' experiences of labour care (Skogheim & Hanssen, 2015; Thelin, Lundgren, & Hermansson, 2014) or explore factors that are associated with women's positive birth experiences (Kennedy, 1995; Lewis, Hauck, Ronchi, Crichton, & Waller, 2016) which has led to serendipitous discoveries about being WW. Our study is the first of its kind which has sought to specifically and intentionally qualify being WW and offers insight into how midwives understand and experience this phenomenon. Our themes confirmed the interconnectedness of midwifery philosophy to midwifery practice and supports assertions within the professional philosophy statement published by the Australian College of Midwives (ACM, 2004). Care that featured the characteristics of being WW identified the practice of midwifery and; in order to be doing 'true midwifery', participants asserted that midwives needed to be WW. This reflects how the two parts (midwifery philosophy and practise) are sections of the same whole. According to the participants in our study, to be 'doing midwifery' it is essential to be 'with woman'.

Midwives in this study worked in different settings, had a range of qualifications and experiences from a variety of models and countries; however all conveyed the importance of being WW to their professional identity. Their rich descriptions reveal how the phenomenon is not unique to any particular model of care, length of experience or previous country of practise and is seen as an integral feature of

midwifery practice. The findings of our research build upon an international study exploring the experiences of 48 New Zealand midwives working in a case-loading model, which revealed that being 'with woman' is a philosophical foundation that identifies the work and purpose of midwifery care regardless of the woman's clinical risk or complexity (Davis & Walker, 2011). The unique knowledge generated from this current WA study confirms that being WW is not dependent on place of birth or a specific model of care but is an identifying feature of midwifery care that occurs in multiple maternity settings.

Building a connection with the woman was expressed as a necessary requirement for being WW by WA midwives. How this connection was developed differed within the varying models of maternity care but the intention was the same; to build a trusting partnership with the woman that facilitated alignment between the woman and her midwife. The midwife-woman partnership is valued by midwives and is acknowledged as an important part of being WW which is confirmed in this study as well as in previous research (Crowther et al., 2019; Crowther & Smythe, 2016; McAra-Couper et al., 2014) and professional commentary (Hunter et al., 2008). This study is the first to present an exploration of midwives' understanding of the complexity, variety and role of developing a connection with the woman; and the way this relates to the phenomenon of being WW in the context of three different models.

Previous research has focused on women's experiences of the midwife-woman relationship, Australian research used a grounded theory approach to interview 14 women, the findings of which determined that women also valued the midwife-woman relationship, which influenced their decision to choose a model of care where this was more likely to be facilitated such as the known midwife models (Davison, Hauck, Bayes, Kuliukas, & Wood, 2015). A metasynthesis of eight Swedish qualitative studies revealed the essential nature of the midwife-woman relationship that includes trust, support and mutuality which, authors asserted, maximise health outcomes for the woman and her baby (Lundgren & Berg, 2007). Our research findings bring a complementary stance from the perspective of midwives and

confirms that building a connection with women is an essential feature of being WW.

The importance of caring for the woman within the context of her family and support people is well published (Jepsen et al., 2017; Thorstensson et al., 2012). By including support people, the midwife offers respectful and inclusive care that meets the woman's needs (Crowther et al., 2016) and has been attributed to reducing feelings of anxiety and helplessness in women (Thorstensson et al., 2012). Whilst midwifery practice that is inclusive of support people is asserted by scholars as an important attribute of quality maternity care (Leap & Hunter, 2016), the fact that providing inclusive care is a manifestation of being WW is new knowledge in the empirical arena. Our research confirms the importance of providing care to the woman that is inclusive of her support people but also proceeds to qualify, that providing inclusive care is in itself, an act of being WW.

The participants in this WA study emphasised that to be WW, it was imperative for midwives to be woman-centred. This stance meant providing care that was focused on the woman, ensuring that it was individualised and fulfilled the needs of the woman rather than care providers or care institutions. This aligns with international midwifery leader Nicky Leap who argues for the importance of woman-centred care and suggests the intention is to bring the locus of control towards the woman rather than health professionals and institutions (Leap, 2009). The mandate for woman-centred care is not a new concept in midwifery practice. Cross sectional research conducted in Japan with 482 women concluded that woman-centred care was valued by women and associated with higher rates of maternal satisfaction, perceptions of control and attachment to their newborns (Iida, Horiuchi, & Porter, 2012). Being 'with woman' and providing woman-centred care are phrases frequently found in midwifery vernacular. Our findings illustrate from the perspective of midwives, how woman-centred care fits within the broader philosophy of midwifery and for the first time confirms that providing woman-centred care is an important construct of being WW.

A number of subthemes were revealed in the midwives' experiences of woman-centred care which reflected being WW. The findings of this study have provided a collection of attributes that midwife participants asserted contribute to the provision of woman- centred care which was seen as the practical manifestations of being 'with woman'. Each of these subthemes has been articulated in previous research expounding the characteristics of 'good' midwifery care but for the first time, has been identified as features of the applied practises of being 'with woman', collectively named by the midwives in our study, as woman-centred care.

All of the practical attributes of being 'with woman' identified by these WA midwives have been previously supported in research or professional commentary as ideal and desirable characteristics of midwifery care, some examples are shown here. Advanced communication skills that encompass listening, understanding, and speaking are recognised as essential skills to provide quality midwifery care (McCourt, 2006; Murphy & King, 2013). The role of the midwife in providing advocacy and facilitating the woman's informed decision making has been presented in international studies emphasising the importance of their inclusion in midwifery care (Cooke, Mills, & Lavender, 2010; Finlay & Sandall, 2009; Freeman & Griew, 2007; Hyde & Roche-Reid, 2004).

A modified Delphi Study conducted in 90 countries by the International Confederation of Midwives interviewed and surveyed midwifery educators and clinicians about necessary inclusions in midwifery curricula regarding knowledge, skills and professional behaviour. Findings confirmed an international consensus that midwifery programs should include education on important midwifery skills such as advocacy that enhances maternal empowerment, facilitation of informed decision making, the importance of the woman-midwife partnership, and the provision of woman-centred care (Fullerton, Thompson, & Severino, 2011). Findings in this WA study revealed how being adaptable was regarded as a necessary attribute to provide care that was centred on the woman and an essential feature of being WW. A well-known UK study which conducted interviews with 11 midwives

found that attributes such as being adaptable and self-aware contributed to professional resilience (Hunter & Warren, 2014).

Being present and proximal to the woman during labour was captured in the WA midwives' descriptions of being WW. Midwives also expressed the importance of providing therapeutic presence, described as a deliberate act of being engaged, attuned, respectful and observant. This theme is supported in a literature review (Hunter, 2002) which included research exploring women's experiences of birth and concluded that both the physical and emotional presence of the midwife during labour and birth formed part of being WW. Midwifery presence, designated as the embodiment of being WW is a key element designed to teach the important skills and attributes of midwives supporting women in labour (Leap & Hunter, 2016). Contrasting features such as being distant and disconnected were also highlighted by WA midwives in our study through descriptions of care that did not display the characteristics of being WW, where a midwife could be performing the 'tasks' of midwifery without being 'present' with the woman. This paradox was confirmed in a Swedish study that interviewed 18 women who had received midwifery care and shared stories where women had experienced similar task-oriented care describing the midwives as being 'absently present' (Berg et al., 1996).

Further confirmation of the importance of midwifery presence was also reported in a Delphi study conducted with 52 midwives and 71 women in the US which sought to offer clarity around exemplary midwifery care (Kennedy, 2000). Midwifery presence was acknowledged as both a process and an outcome that encompasses the art of respect, intimacy, patience as well as creating physical and emotional space (Kennedy, 2000). The authors subsequently asserted that the act of 'being present' may be 'invisible to the unschooled eye ..." (Kennedy et al., 2010, p. 110) which was also expressed by the midwives in this WA study and highlights the importance of being aware of the subtleties and nuanced nature of midwifery presence.

Preparing and guarding a space for women to birth has been previously reported by midwifery leaders as a feature of midwifery care designed to create an environment where women can realise their capacity and agency (Brodie & Leap, 2008; Page, 2008). So too, the concept of therapeutic touch has been offered as an important strategy to demonstrate alliance and engage with the woman, to exhibit trustworthiness through gentleness, kindness and physical touch (Birch, 1986; Peters, 1999).

It is evident that previous research and professional commentary has confirmed the importance of midwifery practices such as effective communication, advocacy, presence and partnership. A unique aspect and new discovery from our WA study is that rather than being isolated features of 'good midwifery care', these attributes are shown to also form part of the collective characteristics of woman centred care which, it is asserted, is the practical manifestation of being WW. Our novel findings reveal midwives' perceptions of how each of these important practices are nested within the broader conceptualisation of woman-centred midwifery practice, evidencing being WW and illustrating the embedded nature of professional philosophy within the work of midwifery.

In the modern techno-rational, task-driven landscape of health care, practices such as 'presence', which may be challenging to identify at first glance, risk being undervalued and eliminated by virtue of their inability to be quantified or measured. The findings from this research are timely in presenting a snapshot of contemporary midwifery care in a variety of settings and from the perspective of midwives who are being 'with woman' within these contexts. The message is clear that being WW is important both to midwives and to midwifery. For the first time, we have been able to offer a conceptualisation of the necessary and common components that midwives perceive are inherent to being WW. The synergies between midwives' descriptions and the professional philosophy statement offered by the Australian College of Midwives are striking (ACM, 2004). Midwives confirmed that being WW is an important and necessary feature of the profession (philosophical identifier); and not only describes the woman-centeredness of the

work (midwifery practise) that we do but also the importance of with whom and how we do it (relationships).

The initial challenge that midwife participants in our study experienced in describing the phenomenon of being WW either directly, or through experience is important information. Despite the challenge, midwives were emphatic that being WW was essential to being a midwife and providing midwifery care. The juxtaposition of a phenomenon that is so central to midwifery and yet challenging to describe highlights the importance of these findings which for the first time, offer a substantial and applied understanding of the constructs of the WW phenomenon from the perspective of midwives themselves. It also draws attention to the importance of developing language around describing philosophical constructs that have applied relevance in our practice-based profession. The explicit descriptions provided in the findings of this study serve to articulate the manifestations or hallmark signs of being WW which are essential for the identification, preservation, and communication of a construct so important to midwifery. Equally, this new and concrete knowledge serves as a basis for reviewing the development of the phenomenon of being WW into the future and acts as a basis for future research as the profession continues to develop and meet the needs of women and their families.

The findings will also be useful to advise midwifery curricula and inform the theoretical and skills-based, practical education of midwifery students. The new knowledge generated, articulates in a tangible way, the recognisable characteristics and manifestations of the phenomenon of being WW. This knowledge can be used to inform strategies to transfer the applied practises of being WW to students of midwifery programs which warrants further research.

## Strengths and Limitations

A strength of this study is the inclusion of midwives who have worked in a variety of models, health services and who possess a range of qualifications and length of

clinical experience. Despite the variety in these factors, the fact that the phenomenon was conceptualised similarly is noteworthy. Midwives self-selected into our study which may indicate that they hold distinctive views about being WW compared to others not interviewed, therefore findings must be considered within this context. The depth of our research discoveries from the experiences of these WA midwives, in conjunction with the rich description of the study context should enable readers to appraise the transferability of findings to varied maternity settings and across other countries.

## Conclusion

Findings from this WA study offer new and important knowledge about how midwives conceptualise the phenomenon of being WW. Some previously recognised 'good midwifery practices' have been shown to contribute to the conceptualisation of woman centred care which, it is revealed in this study, describe the practice attributes of being WW. The findings are substantial, as it provides original evidence of midwives' perceptions of a phenomenon central to our professional philosophy. Knowledge generated will be useful in the education sector as the features of the phenomenon are clearly articulated and able to be built into curricula in a way that links in with the broader philosophy of midwifery. Midwifery leaders and clinical managers will benefit from a greater insight into the embedded nature of midwifery philosophy into practice. Our novel findings confirm the importance of the philosophy of midwifery to its practice and can be useful to inform future maternity service-design in a way that enhances midwives' ability to work and be WW.

Conflict of Interest

The Authors have no conflict of interest to declare

Abbreviations

| | | | |
|---|---|---|---|
| KM | Known Midwife Model | UMKO | Unknown Midwife Known Obstetrician Model |
| US | United States | WW | With woman |
| UK | United Kingdom | WA | Western Australia |
| UM | Unknown Midwife Model | | |

Declarations

**Ethics approval and consent to participate:** This study was approved by Curtin University Human Research Ethics Committee (HREC) (HREC 2016 - 0450). The participants in this study gave written informed consent to be interviewed.

Consent to Publish potentially identifiable information: Not applicable

**Availability of data and materials:** The data generated and analysed from the interviews conducted cannot be made publicly available due ethical concerns around the realistic potential of identifying individual participants from interview transcripts.

**Competing Interests:** The authors declare that they have no competing interests.

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**Author's Contributions**: ZB was responsible for the proposal development, ethics approval data collection, data analysis and the initial and subsequent drafts of the article. YH, MK and RD assisted with research proposal development, data analysis, drafting and refining the final article. All authors read and approved the final manuscript.

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## Chapter Conclusion

This chapter has presented the submitted manuscript of an article (currently under review) that has addressed the study objective of exploring midwives' perceptions of the phenomenon of being 'with woman' during labour and birth. The following chapter presents the published findings addressing the study objective of exploring midwives' experiences of being 'with woman' in the context of the 'known midwife' model.

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# Chapter Five • Midwives' Experiences of Being 'With Woman' in Continuity Models

## Chapter Introduction

This chapter contains the final manuscript of an article accepted and published in BMC Pregnancy and Childbirth. This manuscript addresses the study objective of exploring midwives' experiences of being 'with woman' during labour and birth in the context of continuity models where care is provided by a known midwife. In Western Australia labour and birth care may be provided by a known midwife in a variety of continuity models including midwifery group practice (MGP), community midwifery program (CMP) or privately practicing midwives (PPM). The findings confirm the centrality of the woman- midwife relationship to being 'with woman' and reveal the impact of being 'with woman' on the midwives themselves. Midwives working in a known midwife model acknowledge the benefits to women but also realise the sustaining influence of working in models that more closely align with midwives' professional philosophy.

The journal BMC Pregnancy and Childbirth was selected for this article as it holds one of the highest impact factors (Impact Factor 2.3 for 2017) for the midwifery field of research. This open access, international journal was also chosen on the basis that it would facilitate the distribution of these findings by all who have internet access. The important findings of this research confirm that continuity models facilitate being 'with woman', a concept which is proposed within the philosophy statements offered by the Australian College of Midwives (ACM, 2004) and the International Confederation of Midwives (ICM, 2014) as being central to midwifery practice. The prevalence of continuity models around the world are increasing in line with recommendations by the World Health Organisation (Organization, 2016). Our findings support the call for increased access to continuity

of care by women (de Jonge, Stuijt, Eijke, & Westerman, 2014; Grigg, Tracy, Schmied, Monk, & Tracy, 2015; Perriman, Davis, & Ferguson, 2018) and clarifies through midwives' stories of their experiences that continuity models sustain midwives in practice. Distributing this new knowledge which supports theoretical propositions through a high impact, open access publication will facilitate the global goal of improving maternity services for women. Finally, research findings also reinforce how being 'with woman' in a continuity model also enhances midwives' professional experience. In a post publication clarification, it should be noted that the findings reported in this paper form a distinct component of a single study rather than being one of a series of studies. Confirmation of the fulfilment of copyright requirements is evidenced in Appendix H. Despite being in publication for only two months at the time of thesis submission, there has been keen interest with evidence of engagement including Social Media interaction and distribution as well as inclusion in prescribed reading lists of an Australian Midwifery Course evidenced in Appendix I.

Reference

Bradfield, Z., Hauck, Y., Kelly, M. & Duggan, R. (2019). It's what midwifery is all about: Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model. BMC Pregnancy and Childbirth. ***https://doi.org/10.1186/s12884-018-2144-z*** , 19 – 29.

Title

It's what midwifery is all about: Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model.

## Abstract

**Background:** The phenomenon of being 'with woman' is fundamental to midwifery as it underpins its philosophy, relationships and practices. There is an identified gap

in knowledge around the 'with woman' phenomenon from the perspective of midwives providing care in a variety of contexts. As such, the aim of this study was to explore the experiences of being 'with woman' during labour and birth from the perspective of midwives' working in a model where care is provided by a known midwife.

**Methods:** A descriptive phenomenological design was employed with ten midwives working in a 'known midwife' model who described their experiences of being 'with woman' during labour and birth. The method was informed by Husserlian philosophy which seeks to explore the same phenomenon through rich descriptions by individuals revealing commonalities of the experience.

**Results:** Five themes emerged 1) Building relationships; 2) Woman centred care; 3) Impact on the midwife; 4) Impact on the woman; and 5) Challenges in the Known Midwife model. Midwives emphasised the importance of trusting relationships while being 'with woman', confirming that this relationship extends beyond the woman – midwife relationship to include the woman's support people and family. Being 'with woman' during labour and birth in the context of the relationship facilitates woman-centred care. Being 'with woman' influences midwives, and, it is noted, the women that midwives are working with. Finally, challenges that impact being 'with woman' in the known midwife model are shared by midwives.

**Conclusions:** Findings offer valuable insight into midwives' experiences of being 'with woman' in the context of models that provide care by a known midwife. In this model, the trusting relationship is the conduit for being 'with woman' which influences the midwife, the profession of midwifery, as well as women and their families. Descriptions of challenges to being 'with woman' provide opportunities for professional development and service review. Rich descriptions from the unique voice of midwives, provided insight into the applied practices of being 'with woman' in a known midwife model which adds important knowledge concerning a phenomenon so deeply embedded in the philosophy and practices of the profession of midwifery.

**Keywords**: with woman, midwives, continuity of care, known midwife model, qualitative research, phenomenology

## Background

Midwives being 'with woman' is the central construct of the Professional Philosophy Statement implemented by the Australian College of Midwives (ACM). The Statement confirms how this phenomenon guides the philosophy, relationships and practices of midwives (ACM, 2004). Being 'with woman' is embedded in professional codes and standards guiding Australian midwifery practice (NMBA, 2006a, 2006b, 2008). The importance of being 'with woman' is also referenced in pivotal professional publications from peak midwifery bodies internationally including, Royal College of Midwives in the United Kingdom (UK)(RCM, 2014) and the New Zealand College of Midwives (Guilliland, 2010).

The significance of the midwife-woman relationship is consistently referred to in literature addressing midwives' being 'with woman' (Aune et al., 2013; Berg et al., 1996; Bradfield, Duggan, et al., 2018; Lundgren & Berg, 2007; Thelin et al., 2014) and; working in partnership with women is central to the professional philosophy statement authored by the International Confederation of Midwives (ICM, 2014). However, evidence referring to midwives being 'with woman' is primarily sourced from theoretical writings from midwifery leaders (Fahy, 1998; Hunter, 2015; Hunter, 2002) and studies focusing upon women's experiences of being cared for by midwives (Boyle, Thomas, & Brooks, 2016; Jepsen et al., 2017; McLachlan et al., 2016). Writings from midwifery leaders worldwide emphasize the importance of being 'with woman' and articulate the practice attributes that stem from this philosophical basis such as woman –centred care and working in partnership with women (Fahy, 1998; Guilliland, 2010; Kennedy et al., 2010; Leap & Hunter, 2016). Studies exploring women's experiences have shown that midwives being 'with woman' provides a platform for empowerment and enhances confidence in childbearing women (Berg et al., 1996; McCourt, 2006). Findings of further research confirms that women's experiences and outcomes during labour and birth

are improved when continuity of care is provided by a known midwife and is facilitated by the midwife-woman relationship developed in this model (Boyle et al., 2016; Fenwick, Brittain, & Gamble, 2017; Sandall, Soltani, Gates, Shennan, & Devane, 2016).

Despite the centrality of being 'with woman' to the profession of midwifery, a recent integrative review found that there has been no research that has specifically explored the phenomenon from the perspective of midwives(Bradfield, Duggan, et al., 2018).This research forms one component of a series of studies undertaken in other models where care is provided by unknown midwives (standard public care)(Bradfield et al., 2019b) or unknown midwives and known obstetricians (private obstetric models) (Bradfield, Kelly, et al., 2018) which revealed the importance of building a connection with the woman and the centrality of 'relationship' to the practices of being 'with woman'. In light of the contribution of the midwife-woman relationship to being 'with woman' (Fahy, 1998; Leap, 2009; Leap & Hunter, 2016), the intersection between the models that enable care during labour and birth by a 'known midwife' and the 'with woman' phenomenon warrants exploration.

The aim of this study was to explore Western Australian midwives' experiences of being 'with woman' during labour and birth in the context of a model that facilitates care by a known midwife.

## Methods

### Research Setting

In Western Australia (WA), the opportunity for women to receive care in labour and birth by a known midwife is available through a number of existing midwifery continuity of care programs. The Community Midwifery Program (CMP) is a publically funded midwifery-led service that provides continuity of care from a known midwife from 16 weeks of pregnancy, throughout labour, birth and for up to two weeks post birth. Women who live within a 50km radius of the Perth Central

Business District, and meet the criteria may self-refer and elect to birth in their own home, at WA's only Birth Centre located adjacent to WA's only tertiary maternity service or, at a participating public hospital (DOHWA, 2013, 2017a).

Midwifery Group Practices (MGPs) provide care to pregnant women in a group of (4-6) midwives. The woman has the opportunity to meet with and receive antenatal care by each of the midwives in the group, with a commitment that two of the midwives will be present for the birth. MGPs offer care to women booked to birth in participating public hospitals, the woman's home (DOHWA, 2013) (1 rural site) as well as the state's only birth centre. Within WA, MGPs are coordinated differently at each site (DOHWA, 2017c). Women are cared for primarily by midwives and where required, in collaboration with medical specialists according to the woman's health needs, policy of the health agency and in conjunction with the National Midwifery Guidelines for Consultation and Referral (ACM, 2013).

A final option is to employ the services of a midwife in private practice where women recruit and contract with individual midwives to provide care across their childbearing experience. Women using this model usually birth in their own homes although there are a number of midwives in private practice who have access agreements with public hospitals that may enable admission under the care of the midwife as explained in the information published by the Department of Health in Western Australia (DOHWA, 2013). Each of these three models of care (CMP, MGP and Midwives in private practice) enable the woman to receive care during her labour and birth by a known midwife.

Phenomenological research explores the lived experience of participants in a way that relays the essences and meanings of a phenomenon (Whitehead et al., 2016b). This study employed a framework for descriptive phenomenological research developed by Giorgi (Giorgi, 1997, 2012). Giorgi's work is informed by the Husserlian philosophy of Phenomenology which focusses on descriptions of the same phenomenon as it manifests itself to different individuals and reveals commonalities of the experience (Giorgi, 1997; Husserl, 2012). A descriptive

phenomenological methodology offers an ideal opportunity to gain further insight into the applied practices or experiences of the 'with woman' phenomenon from the perspective of midwives working in a 'known midwife' model as it uncovers the constituents of phenomena that have not been conceptualised by prior research (Finlay, 2013; Lopez & Willis, 2004; Moustakas, 1994). Descriptive phenomenology is also useful to gain an understanding of the eidetic structures of a phenomenon in a way that "...neither adds nor subtracts from the invariant intentional object arrived at, but describes it precisely as it presents itself" (Giorgi, 2009, p. 137).

Purposive sampling of midwives working in one of the 'known midwife' models described above led to snowballing and the recruitment of midwives into this study. Snowball sampling is useful when information gathered from 'purposefully sampled' participants connects the researcher to other potential participants (Whitehead et al., 2016b). The inclusion criteria were: midwives who had provided labour and birth care in a model that facilitates care by a known midwife in the last 12 months to mitigate recall bias. Ten female midwives participated in the study ranging in age from 35 to 57 years with between 4 to 34 years of midwifery experience. All had previously worked in public hospital based maternity systems that offered fragmented care where care was provided to labouring women not known to them. Demographic profile is presented in Table 1.

**Table 1. Demographic profile (n=10)**

| Demographic variables | Number of participants |
|---|---|
| Age | |
| 30 to 40 | 2 |
| 41 to 50 | 5 |
| 50 to 60 | 3 |
| Years of experience as a midwife | |
| < 5 years | 1 |
| 5 to 10 years | 3 |
| 11 to 15 | 3 |
| 16 to 20 | |
| 21 to 25 | 1 |
| 26 to 30 | 1 |
| 31 to 35 | 1 |
| Method of midwifery education | |
| Hospital – based diploma | 3 |
| Undergraduate midwifery degree | 3 |
| Postgraduate midwifery qualification | 4 |
| Country of midwifery education | |
| Australia | 6 |
| United Kingdom | 3 |
| New Zealand | 1 |
| Previous midwifery model | |
| Public hospital non-continuity model | 10 |
| Private hospital obstetric model | 1 |
| Current midwifery model | |
| Privately practicing midwife | 2 |
| Midwifery group practice | 8 |
| Total | 10 |

## Data Collection

In depth interviews were conducted, digitally recorded and transcribed verbatim. Midwives were asked to describe their experiences of being 'with woman' during labour and birth and to reflect on any intersection on the phenomenon in the context of the 'known midwife' model. In- depth interviews lasting on average, over an hour long were conducted between December 2016 and May 2017 by the first author (ZB) at a time and place convenient to the midwives. The interviewer, a midwife academic, was known to two midwives, however the potential for influence on participant responses was limited as the researcher was not working in a clinical setting with any of these midwives. Throughout the interview process, the practice of phenomenological reduction was adopted which involves suspending personal assumptions or prior knowledge of being 'with woman' and considering the phenomenon as it was described (Giorgi, 1997, 2012). Field notes and a research journal were maintained, which offered the opportunity to bracket any pre-existing thoughts and to reflect post-interview (Ortlipp, 2008). Pre-brief and de-brief with the rest of the research team (YH, MK, RD) was also used as a strategy to enhance bracketing. Midwives were offered the opportunity to send additional comments after the interview to the researcher. Two midwives provided further comments via email and two via a phone call. Data saturation was becoming apparent after eight interviews and a further two interviews were performed so the research team were able to confirm further data was not generating new information (Fusch & Ness, 2015).

## Data Analysis

Data analysis was guided by Giorgi's four stage phenomenological approach: (1) data immersion, (2) dividing data into parts, (3) organisation and transformation of data and (4) expressing of the constituents of the phenomenon (Giorgi, 1997). Transcripts were read and re-read with repeated listening of the audio recording to facilitate immersion in the data. Conceptualisations known as 'meaning units' were extracted. Qualitative data analysis software NVivo (version 11) was employed for

classification and arrangement of data. Step three facilitated organisation and expression of data into the language of the profession. As participants described their experiences, the ways of experiencing the phenomenon were revealed. Here, statements were transformed from everyday language to concepts that Giorgi (1997, p. 247) maintains, are revealed through the researcher's disciplinary intuition. The final step involved developing the key constituents (expressed as themes) and essences (expressed as sub- themes). These concepts were supported by direct quotations from interviews which are indicated in italics with a unique identification code (P1 to P10) to ensure confidentiality of the participants. To enhance clarity and for brevity, non-italicised words in square brackets [ ] have been inserted by the researcher to provide context to descriptions and; where words were omitted this is indicated by an ellipsis (…). The first author conducted the interviews and analysed all transcripts. Each transcript was analysed by at least two members of the research team. The team then met to discuss preliminary findings and consensus was reached around final themes and subthemes adding rigor to the analysis. Using NVivo 11, a Word Cloud was also generated from the interview transcripts which highlights the midwives' language when sharing their experience of being 'with woman'. Word Clouds are increasingly used in qualitative research as a way of enhancing transparency and drawing attention to the dominant narrative evidenced by more frequent words appearing in bold and larger font (Heimerl, Lohmann, Lange, & Ertl, 2014; McNaught & Lam, 2010; Tong, Flemming, McInnes, Oliver, & Craig, 2012; Vanstone et al., 2016).

## Results

Analysis of midwives' experiences of being 'with woman' in the context of a 'known midwife' model revealed rich descriptions that offer insight into how the model intersects with the phenomenon. Five main themes were identified, 1) Building relationships; 2) Woman centred care that is safe; 3) Impact on the midwife; 4) Impact on the Woman; 5) Challenges in the 'known midwife' model along with corresponding subthemes (Figure 1). The dominant narrative presented during the

midwives' interviews as illustrated in the Word cloud (Figure 2) complements the identified themes.

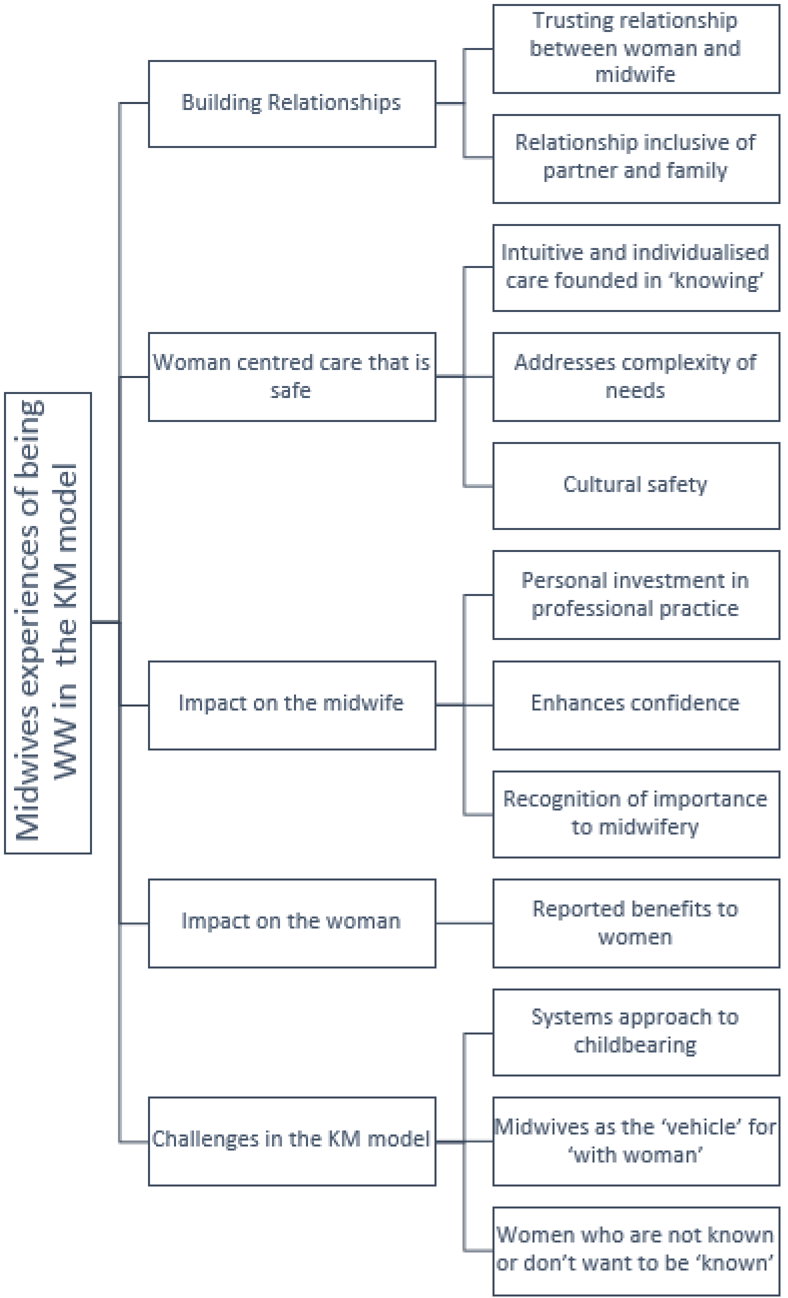


**Figure 1. Themes and subthemes: Western Australian (WA) midwives' experiences of being 'with woman' in known midwife (KM) models**

## Building Relationships

### Trusting relationship between woman and midwife

Midwives working within the 'known midwife' model shared their experience of developing a professional relationship with women as a consequence of working closely together for months. Descriptions were shared around how working with women in the intrapartum period was based upon an established relationship that enabled the process of being 'with woman'. Midwives were asked to reflect on the intersection of the model and being 'with woman' in the intrapartum period. However, when sharing their experiences, midwives consistently referenced care provided across the childbearing continuum suggesting that in this model, being 'with woman' cannot be isolated to intrapartum care and is integrated across the childbirth continuum.

Whilst providing care during labour and birth, this established relationship characterised by trust is a significant element of being 'with woman'. As one midwife suggested

*…you have that trust, a real trust in each other that was developed over time that you both rely on actually. She trusts you to make the right call and you trust her for her body to work efficiently and do what is necessary in the space that you've created* (P9).

This trusting relationship, sometimes conveyed as a partnership or professional friendship, was acknowledged by midwives as the key to the success to being 'with woman' during labour and birth in the 'known midwife' model: *I think first and foremost it's the relationship… it becomes close to a friendship type of relationship… a respectful partnership and relationship between the midwives and the women* (P2).

Being able to provide woman - centred care was central to the 'knowing' created as a result of relationship-building during pregnancy.

*It's like you've got that friendship already before you go in the room…as soon as you walk in the room the atmosphere's different. We know each other and it's relaxed and it's, happy…my experience on MGP has been much better of having that sense of being with woman because I've had that continuity* (P4).

Midwives felt the relationship that developed, enhanced their ability to connect with the woman and her journey rather than being associated with a set of clinical tasks: *Your relationship with the woman grows like the baby grows: It's a journey you make as well with the woman it's not just the woman and her family but it's really the partnership with them* (P7). Building the relationship during pregnancy contributed to the commitment and 'knowing' required to offer support during labour and birth: …*having that journey beforehand that helps you feel that commitment and that onus to do well … in birth I guess for that woman* (P8).

### Relationship inclusive of partner and family

When describing the importance of relationship building, the midwives clarified that although the primary relationship is with the woman, a relationship also developed with the partner and other family members: *It [relationship] improves it [being with woman] because of the knowledge, because of knowing the family, knowing where they come from, know where they live, know what their background is… so that helps you antenatally but also for labour* (P7). The relationships built across pregnancy connected the midwife to their journey and allowed the midwife to situate the woman and her family at the centre of the care experience.

## Woman centred care is safer

### Intuitive and individualised care founded in 'knowing'

Building trusting relationships facilitated a deep 'knowing' of the woman and her significant other, which enhanced the midwife's ability to offer intuitive individualised care: …*you've had the opportunity to have a discussion as to exactly what they want from their experience before you're meeting a woman in labour*

*who possibly can't communicate that as well* (P6). Multiple examples were offered to illustrate how the relationship and deep level of knowing what the woman wanted for her birthing experience facilitated meeting her needs as they evolved across the intrapartum period. Interactions described during the care experience revealed how intuitive care was possible.

*…it was just literally eye contact, me knowing that lady, knowing what she wanted, where she wanted to be … watching her body, watching what she was doing … I could pick up on that and jump in when it was relevant* (P4).

Another midwife characterised this process as being in tune with the woman, almost like a reciprocal dance where the midwife could respond appropriately to the woman's needs.

*You've had plenty of time and you know what her worries are but you also know what her insecurities are, you also know what her medical problems are and how you can look for that … you're in tune with all of that it just forges the path forward and just makes it kind of clear and open so she's able to walk that path with you by her side having that awareness* (P9).

A final example reflects how the midwife can facilitate a woman's individual path in choosing a different course of action than might be initially recommended: … [*If] that approach is not going to work for her … I'll try one other thing… I think if you're a midwife who is working 'with woman' … you will become the midwife who writes 'declined'* (P2).

Midwives shared how being 'with woman' helped them to provide care reinforced by a sense of safety. Stories revealed how the relationship founded in trust and knowing of the woman's health and preferences plus her family situation enabled them to feel more confident in their care:

*Working with the woman in a continuity of care model I feel safer as a midwife. I feel the knowledge I have of that woman, of her partner, of her needs, because I know her so well I'm safer* (P1). Another midwife noted:

*I feel safer looking after women who I know because I know their history very well. I know them inside out. I know what their normal situation is, what their medical history is; little things to look out for and know when to move, when to kind of change direction, when to think ok now we need to do something different* (P9).

### Addresses complexity of needs

Midwives described how developing a close relationship assisted them to feel better equipped to care for a labouring woman whose pregnancy was complex from the outset or changed during pregnancy. Knowing the woman, her clinical issues plus her hopes and plans for her birth experience enhanced midwives' ability to be 'with woman' and support the woman's choices. Having time within the 'known midwife' model to attend obstetric consultations and facilitate authentic collaboration with care decisions put the woman at the centre of the care experience.

*… particularly if you've got women that have complex issues, you've got a full 4, 5 months of being with them to learn more about that problem rather than trying to be thrown in the deep end with someone in labour… you know their story, you know what they want, you get to spend more time with them, physically supporting them as opposed to have to sit there and read through their volume of notes to find out why does this woman not want this* (P5).

### Cultural safety

The midwife and woman relationship characterised by understanding, knowing and trust facilitated care that was responsive and respectful to women and families from diverse ethnic and cultural backgrounds. This relationship fostered culturally safe care. As one midwife recounted:

*I work a lot with Indigenous women, facilitating those relationships during pregnancy has made birthing so much more easier and … opens you up to the community because they know who you are and who you represent* (P3). This trusted, respectful relationship broadens the traditional view of cultural safety that

focuses on individuals from ethnic minority groups. One midwife noted that being 'with woman' requires an approach that considers each woman's journey: *…this is her journey… cultural safety is really about not just different ethnicities it's also about … other people's experience or other people's lives* (P7).

## Impact on the midwife

Midwives' experiences of being 'with woman' during labour and birth in the 'known midwife' model revealed the impact of the phenomenon on midwives and the midwifery profession.

### Personal investment in professional practice

Midwives spoke of the emotional impact that being 'with woman' has on them which requires self-awareness as participant (P4) shared: *If you've got midwives who do acquire the skill of emotional intelligence… they definitely have the ability to be with woman more*. The process of being 'with woman' engaged not only midwives' professional identity but also connected at a personal and individual level: *It's the emotion that I invest in that woman… and it's not just of her it's of her and her partner and other children, it's very, very, very personal* (P1).

Personal investment in a professional practice was an act of personal and professional integrity which enabled midwives to be true to themselves and not just to the women … *without knowing the women, it just wouldn't be the same either so unfortunately it's all or nothing from me… if I'm going to be around birth… I just can't see it any other way (P8).*

Midwives confirmed their commitment to working in a model that respects both midwives and women. One midwife highlighted these outcomes as:

*I know the hours I spend looking after women in the continuity of care model, if I spent those hours in a medical model… I would earn a lot, financially I would be so much better off but I know I would hate myself* (P1).

Midwives acknowledged that being 'with woman' in the 'known midwife' model did come at a 'cost'. *There's a cost in terms of sleep and exhaustion and family time and being on call, yes there's lots of costs to do that (P8).* The connectedness that develops through the relationship results in an investment that sees midwives riding the highs and lows with the women.

*Sometimes you take it home at the end of the day it can be draining… the hours are unsociable, they're often long. You know it can be physically and emotionally draining* (P5) but then also note: *…it's more than made up for when I work in a model that like I'm in now…when you've had that full experience from beginning to end with a family…It definitely makes up for it* (P5).

### Enhances confidence

Midwives reported a sense of confidence and security that arose from being 'with woman' during labour and birth in the context of the trusting relationship that develops in the 'known midwife' model. The confidence and security develops from the mutually trusting relationship and facilitates an environment where midwives have freedom and space to observe and respond to the woman's needs *Wow that worked, ok we'll do that next time…* [*if] that kind of situation presents I can do that again… So because I get the opportunity to practice I get … to see it work* (P2). The relationship that 'gives' to the woman also 'gives' to the midwife:

*…being able to recognise a situation and change it enough to help her achieve what she wants to gives you almost as much confidence as having the baby yourself you know… So I think that* [being with woman] *would give midwives more confidence to speak out and I think it's important for women* (P2).

### Recognition of importance to midwifery

There was unequivocal agreement that being 'with woman' is an important part of midwifery practice: *Absolutely, 100 percent no doubt it's [being with woman] what you do the work for, you know* (P6). There was caution expressed that the skill of being 'with woman' is at risk of being lost: … *it's important for midwives because*

*lots of midwifery skills are being degraded or down-graded or lost* (P2). The importance of being 'with woman' extended to not just the practice of midwifery but to the very identification of what a midwife is: … *it's absolutely essential because without it [with woman] you're not a midwife* (P9).

The reward and fulfilment of being 'with woman' during labour and birth was acknowledged as a sustaining force that kept midwives engaged and committed despite the costs and challenges: *…you're in that space with this woman and it's really personal and it's really intimate and that's really special… then it's rewarding… like, that's what it's about* (P10). The relationship that develops in this model enhanced midwives' ability to practice in accordance with their professional philosophy contributing to job satisfaction.

*… my experiences of being with woman are better for me on MGP… to know I've had that with woman… the fact that I've made that difference is really, gives me really good job satisfaction* (P4). This is echoed by another midwife … *it's* [being with woman] *why you do the job… I feel I get more out of my job when I have known them before* (P5).

Midwives acknowledged the privilege of working with women and their families: *I was talking to my sister last night about how privileged our job is and that you share in the most amazing moments* (P6) and that this sustains a commitment to the profession: *I can't really imagine doing anything else* (P3).

## Impact on the Woman

Midwives offered insights into their observations of the benefits that women might experience based on the feedback from women they had cared for.

### Reported benefits to women

Midwives reported that 'with woman' care during labour and birth improves women's birth experiences by enhancing respect and dignity**.** *The feedback we get from the woman is that they felt that they were treated with respect, dignity… not*

*just being that clinician, it's about actually being decent to people* (P3). Midwives shared how women valued the guidance that was provided:

*… the other thing women say is, you knew exactly what to say at the right times* (P6). According to midwives, women also reflected upon the relationship and how it sustained them during times of difficulty: *I get a lot of feedback from women that say 'oh my God that's what got me through* (P6). Being 'with woman' in the context of the professional relationship contributed to women sharing with their midwife: *She* (the woman) *said 'I felt like I was in control, I felt like I made decisions'… she said to me 'I never thought I'd have a relationship with my midwife like I have with you'* (P6). Midwives observed women being empowered: *That's what you've done by being with woman… she will labour efficiently and she'll feel so proud of herself afterwards to have done it under her own steam* (P9).

Midwives also shared how women compared their experiences based upon exposure to models of care where the midwife is not known to them.

*Women who have had experience in both models will actually tell you that there is a difference. It was so important for her to achieve a VBAC* [Vaginal Birth after Caesarean]. *It couldn't have actually worked out any better… She says 'I cannot even begin to tell you the experience', she says 'they were incomparable … the whole experience, but particularly the birth'* (P3).

For many women, the stories shared with midwives confirm how the relationship with the midwife provided a source of healing and reconciliation of previous traumatic birth experiences: *She was very vocal about that* [previous experience] *and she was like 'that was just such a healing birth for me' … That to me was what being with woman was about* (P5).

## Challenges in the Known Midwife Model

'Systems' approach to childbearing

The 'systems' approach to maternity services that favour standardisation over individualised care can present a barrier to being 'with woman' during labour and birth. Midwives reflected on their previous experiences of being 'with woman' during labour and birth in other models, and some, from other countries. As one midwife noted:

*… the lack of understanding on the establishment side and the medical side of midwifery-only care ... hospitals' lack of willingness to work with midwives that choose to work in this model is a really big inhibitor… it's worked … in the UK, where the medical obstetric profession and midwifery are very much on an even level and they've worked together forever … we're all her carer, so long as she gets the right care that's what matters. I still find it absolutely frustrating the way the system dictates to women you will or won't have and that midwives can or cannot… that's the biggest inhibitor to working in this model* (P1).

Midwives shared how the requirement for medical involvement in the care of women impacts the relationship between midwives and women … *within the hospital system, that relationship constantly gets eroded and women must be aware of that* (P2).

Midwives felt that the phenomenon of being 'with woman' is unfamiliar in the context of biomedical approaches to maternity care and perceived as of less value.

…*it's* [with woman] *not supported in the majority of places where midwives work or models of care that midwives work in it's not an acknowledged skill really. It's not considered important, it's not evidence based, it's not scientific… it's not supported and it's not promoted as valuable* (P2).

Another midwife expressed frustration with communicating the importance of being 'with woman'.

*… it's a matter of, for us to be able to put it* [with woman] *in a language that doesn't seem so tree hugging … what we do is both an art and a science, so how do you find that, for something that we know* (P3).

Midwives recounted a blurring of the lines of accountability when unknown practitioners enter the woman's birth space and interrupt being 'with woman'.

*We're in labour ward but we have other members of staff on labour ward. So you have the coordinator and you have the GPs* [general practitioners] *and you have the specialist obstetricians and sometimes I think when that model* [medically-led care] *comes into my room with my woman that affects me being with woman* (P4).

This contrasts with descriptions of when labour and birth occurs at a birth centre, or the woman's home: *Your role is going to be different when you're at home and everything's going well, she's in the zone and things are really smooth then you're really her support, facilitator and guardian, making sure it all goes according to plan* (P9).

Midwives also reflected on the limitations of service availability such as when there were more women wanting maternity care in a 'known midwife' model than there were midwives to provide it.

*I think that one of the other things that's really impacted upon my ability to be able to be there with women is that the demand for our services is outstripping the supply and it's very hard to say to a woman I'm sorry but you haven't made it on the programme … that's been a challenge not to be able to give every woman that service* (P3).

Another limitation was seen as the rationalising of antenatal visits in some services.

*It's continuity of care of course but then we see them at 15 weeks and then we don't see her, then 'til 24 weeks. So it could be better, could be earlier… for some women they need more time to build the relationship* (P7).

### Midwives as the 'vehicle' for 'with woman'

Midwives described the potential for personality clashes to impact on their ability to be 'with woman': *Personality … would be the only thing that would come up, but in my experience, in the antenatal period this has been resolved* (P2). Midwives recognised that their own personality may, in some circumstances provide an obstacle: *I think that your own personality causes a barrier to be honest… some women you don't particularly gel with* (P10). Midwives offered insights into how they personally can impact on being 'with woman' and shared openly how this happens and strategies to overcome these challenges. One insight related to personal pressures affecting mood.

*When you're not feeling up to it and you have to put yourself in the right mood but as soon as it* [labour] *starts it gathers momentum and becomes easier and flows really nicely … if you're not in the right space then it doesn't take much to flick you over and see the power and the beauty of what's before you and help to make that happen* [being with woman] *if you're in your 'with woman' zone it helps the woman to be in her zone* (P9).

Midwives spoke about how their own fears from past personal or professional experiences, influenced their ability to be with woman and how they learned to overcome this: … *we project our own fears and our own baggage into what the woman is saying but this is not your journey this is her journey… I learned a lot about, not projecting what I felt or what experience* (P7). Fear of ridicule from colleagues was also acknowledged as a challenge: *I think then there's the scared of being told that they're weird or there's no science behind that, like being fobbed off because they do they make you feel unintelligent or because you believe in that [being with woman]* (P2).

### Women who are not known or don't want to be 'known'

Despite continuity of care being a key characteristic of the 'known midwife' model, a midwife may be called to care for a labouring woman in another team or to care

for a woman booked to a privately practising midwife who is not available. Midwives reflected on the impact of being 'with woman' during labour and birth for a woman they have not provided antenatal care for.

*… it is different but … even if we haven't met the woman specifically, we all know something about each other's women… we're all continuously talking so most of the time even if I haven't met the woman I know something of her and something of her wishes* (P5).

Although, not commonly reported in this research, midwives described how a woman can dismiss and not recognise the relationship opportunity in a 'known midwife' model. Women who may decline 'relationship' are still offered respectful care during labour and birth: … *there's other women who as long as you're clinically there and doing everything right and everything's getting addressed they don't have that 'with woman' connection … doesn't matter which midwife they had* (P4). Another midwife shared a scenario where: …*she just was a woman who actually she didn't want me in her space, she didn't want me to be involved, she just wanted me to do the birth … she didn't want her husband or … no input from him and you know she said just don't f***ing touch me* (P6). Midwives acknowledged how being 'with woman' in these situations means being respectful of a woman's wishes by providing care less focussed on the relational aspects of care.

## Discussion

The findings from this study confirm the importance of respectful, professional relationship to the practice of being 'with woman' which enhances midwives' ability to provide woman – centred care. Although being 'with woman' is a phenomenon with a philosophical origin, the application of this practice impacts midwives, the profession of midwifery as well as women and their families. The challenges described by midwives also offered insight into how being 'with woman' intersects with various models of care and places of birth.

## Relationship is key

Western Australian midwives' experiences of being 'with woman' during labour and birth in the context of the 'known midwife' model is permeated by the trusting relationship between the midwife and woman that is central to this model of maternity care. Midwives' ability to be 'with woman' during labour and birth is enhanced by the knowing and trust that comes out of the relationship developed in the antenatal period (Davison et al., 2015). The various embodiments of 'knowing' in midwifery practices have been written about in midwifery literature globally (Davis, 1995; Hunter, 2008; Ólafsdóttir, 2006), the importance of the 'knowing' that comes from relationship is confirmed in our findings as highlighted visually in the word cloud generated from the interview transcripts (Figure 2).

**Figure 2. Word Cloud generated from all interview transcripts using NVivo 11.**

Because the relationship is developed in the antenatal period, being 'with woman' during labour and birth commences during pregnancy when relationships are being built. Midwives' descriptions reveal new evidence that being 'with woman' in the 'known midwife' model is inextricably linked to whichever stage of the childbearing continuum the woman finds herself in. Being 'with woman' in the 'known midwife' model is not isolated to the labour and birth experience which is an important and new finding in this study. Although there are a small number of publications that refer to examples of being 'with woman' in the antenatal (McCourt, 2006) or postnatal period (Lawton & Robinson, 2016), many of the writings that address midwives being 'with woman' predominantly refer to labour and birth (Berg et al., 1996; Davis & Homer, 2016; Hildingsson, 2015; Hunter, 2009). Further research is warranted into how being 'with woman' is developed during pregnancy and sustained across the childbirth continuum.

Historically, the concept of being 'with woman' has been criticised for being exclusive to others including the woman's partner or family (Carolan & Hodnett, 2007). Our research findings confirm the theoretical writings from midwifery leaders that propose inclusion of the woman's partner and family as an essential component of 'with woman' philosophy and practices offers important new evidence (Crowther et al., 2016; Jepsen et al., 2017; Leap, 2009; Thorstensson et al., 2012). Building knowledge around the phenomenon of being 'with woman' from the perspective of the partner and significant family members should also be a focus of future research.

### Woman centred care

Being 'with woman' during labour and birth in the context of the relationship that is formed in the 'known midwife' models, facilitates intuitive and individualised care placing the woman and her family at the centre of the care experience. Midwives' descriptions of this align with what is understood in the theoretical domains about woman-centred care as being an integral element of the 'with woman' philosophy (ACM, 2004; Berg, Ólafsdóttir, & Lundgren, 2012; Homer et al., 2009; Leap, 2009)

but is presented empirically for the first time here.  Being 'with woman' in the 'known midwife' model transcends maternal risk and has been shown to act as a buffer to women whose clinical condition changes throughout pregnancy as well as labour and birth (Allen, Kildea, Hartz, Tracy, & Tracy, 2017; Allen, Kildea, & Stapleton, 2016; Kuliukas, Duggan, Lewis, & Hauck, 2016) . The relationship that develops in the 'known midwife' model enhances midwives' ability to be 'with woman' by providing culturally safe care, particularly for Indigenous women or those from a culturally and linguistically diverse background. This is consistent with findings from other Australian authors that assert that the relationship in 'known midwife' models positively influences cultural responsiveness (Corcoran, Catling, & Homer, 2017; Josif, Barclay, Kruske, & Kildea, 2014; Kelly et al., 2014) .

### Impact of being 'with woman' in the context of the 'known midwife' model

Being 'with woman' during labour and birth in the 'known midwife' model impacts on midwives, the profession of midwifery, women as well as their partners and family. Midwives described their personal investment in professional practice as they gave from themselves in order to be 'with woman'. This phenomenon of how the broader work of midwifery intersects with midwives' emotions and humanity has been previously explored in works by Fenwick et al (2018) and Hunter and Deery (2005). The important and new finding of how being 'with woman' enhanced the confidence of the midwives is supported by Kennedy et al (Kennedy et al., 2010) who describe the similar practice of midwives being 'present' during labour and birth as an essential feature of midwifery . The novel discoveries in this research confirm that the relationship that is formed in the 'known midwife' model provides an environment that enhances midwives' ability to be reflexive in practice. In addition to this, the space that was created through the trusting relationship encouraged midwives to try new ways of being 'with woman' which supports professional development and future care of women, their partners and family. Although not specifically seeking to understand the phenomenon of being 'with woman', recent evidence suggests continuity models enable and motivate

midwives to invest in and extend their practices contributing to greater satisfaction in women (Allen et al., 2017; Newton, McLachlan, Forster, & Willis, 2016)

The findings from this study emphasise the importance of being 'with woman' to the profession of midwifery and confirm that being 'with woman' contributes to identifying what it means to be a midwife. This debate has been raised in earlier writings as well as the findings of recent research (Barker, 2010; Bradfield, Duggan, et al., 2018; Hunter, 2003; Newton et al., 2016). Importantly, midwives confirmed that being 'with woman' during labour and birth in the 'known midwife' model was rewarding and sustaining. Indeed, findings from recent research showed that midwives experienced greater satisfaction when working in models that support their professional philosophy (Crowther et al., 2016; McAra-Couper et al., 2014; Skogheim & Hanssen, 2015). Given the debate surrounding 'with woman' as being essential to being a midwife, research into midwives' perceptions is recommended around whether midwifery care can be delivered in the absence of being 'with woman' within the context of different models of maternity care.

Midwives' descriptions of the benefits, reported by women who received 'with woman' midwifery care during labour and birth in the 'known midwife' model included characteristics recognised in international literature such as guidance, respect, dignity and empowerment (Kennedy, 2000; Kennedy, 1995; Kennedy et al., 2010). Midwives also highlighted that women who had previously experienced labour and birth care by an unknown midwife commented on the difference between the two models and appreciated the relationship with the midwife in the 'known midwife' model. Whilst maternal outcomes and satisfaction rates are consistently rated positively by women in continuity of care models (Sandall et al., 2016), there is no current evidence that captures women's experiences across different models of maternity care, which also warrants further research. Similarly, further research is warranted to explore midwives' experiences of working in different models.

### Working through the challenges

Several factors challenged midwives' ability to be 'with woman' during the intrapartum period within the 'known midwife' model context. A 'systems' approach to childbearing that favours standardisation over individualisation of care and 'throughput' over relationship is acknowledged as a known barrier to woman-centred care (Page, 2003) in this study, it is also shown to impact the phenomenon of being 'with woman'. Where 'known midwife' models of care are required to intersect with these systems either through formalised structures or places of birth this challenge becomes apparent (Davis & Homer, 2016). This issue is not unique to the Western Australian maternity landscape and is supported in the writings of midwives from the USA, (2016), UK, (2007; O'Connell & Downe, 2009)and Norway, (2015).

Midwives acknowledge the human aspect of working 'with woman' and their families which highlights how personality or feelings of the midwife and woman may offer a challenge to being 'with woman'. Midwives demonstrated their resilience by offering strategies to address the issue of not feeling 'up to the task' which offers the first, ever insight into how midwives reconcile the challenges and rewards of being 'with woman' The concept of 'emotion work' in midwifery is an emerging topic and focuses principally on the emotional impacts on midwives (Berg, 2005; Fenwick et al., 2018; Hunter & Deery, 2005). Further research is warranted on the impact of interpersonal constructs of personality clashes in maternity care. The realisation that some women do not want to be 'known' and prefer clinical and practical care over an experience founded in relationship during labour and birth has not previously been reported and should be explored.

## Strengths and Limitations

A strength in this research study includes the collection of data from midwives currently working in a 'known midwife' model but who also had experience working across a range of 'known midwife' models and models where the midwife is not

known to the woman. This focus enabled these WA midwives to reflect upon the intersection between being 'with woman' in the context of the 'known midwife' models including MGP and private practice. It could be asserted that self-selection into this study suggests that midwives recruited from 'known midwife' models may hold distinctive views of being 'with woman' compared to views of midwives working in other models of care and findings must be considered within this context. The richness of the data presented allows the reader to determine any potential transferability of the findings to other models of care.

## Conclusion

Our findings provide insight into midwives' experience of being 'with woman' while providing care during labour and birth within the context of a 'known midwife' model. Being 'with woman' in this model is underpinned by a trusting relationship that influences not only the midwife and woman, but her partner, family and the profession of midwifery. Findings confirm some previously understood concepts about the phenomenon of being 'with woman' but also highlight new insight that has never been acknowledged from the previously overlooked but unique voice of midwives working in this model of care. Understanding midwives' experiences of being 'with woman' as well as the challenges they face, offers the opportunity for service providers to explore innovative ways of facilitating 'with woman' care in this model. Insight into the applied practices of being 'with woman' in a 'known midwife' model adds valuable knowledge around a phenomenon that is central to the profession's philosophy and practice.

List of abbreviations

| | | | |
|---|---|---|---|
| WW | With woman | KM | Known Midwife |
| MGP | Midwifery Group Practice | WA | Western Australia |
| CMP | Community Midwifery Program | UK | United Kingdom |
| ACM | Australian College of Midwives | US | United States of America |

Declarations

**Ethics approval and consent to participate:** This study was approved by Curtin University Human Research Ethics Committee (HREC) (HREC 2016 - 0450). The participants in this study gave written informed consent to be interviewed.

Consent to Publish potentially identifiable information: Not applicable

**Availability of data and materials:** The data generated and analysed from the interviews conducted cannot be made publicly available due ethical concerns around the realistic potential of identifying individual participants from interview transcripts.

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## Chapter Conclusion

This chapter has presented the final, published manuscript of this exploration of midwives' experiences of being 'with woman' in the unique context of the continuity models where care is provided by a known midwife. The next chapter presents the published manuscript addressing the study objective exploring midwives' experiences of being 'with woman' during labour and birth in the context of the 'unknown midwife' model labour and birth care is provided by midwives not known to the woman.

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# Chapter Six • Midwives' Experiences of Being 'With Woman' in Models Where the Midwife is Not Known

## Chapter Introduction

The following chapter presents the final manuscript of an article which was accepted and published in Midwifery Journal. This manuscript addresses the study objective of exploring midwives' experiences of being 'with woman' during labour and birth in the context of fragmented maternity models where care is provided by an unknown midwife. In Western Australia, the majority of midwives are employed in the standard public model which provides fragmented care to childbearing women (DOH, 2017). In this setting, midwives provide care during labour and birth to women who are not known to them. The practice of being 'with woman' is uniquely experienced by midwives working in this model.

Findings reveal the skilful way in which midwives working in this model prioritise developing a rapid connection with the woman in order to facilitate a trusting partnership. Adaptability and self-awareness were highlighted as attributes that enhanced being 'with woman'. Midwives described factors unique to the unknown midwife model which intersected with the phenomenon of being 'with woman' and reported the rewards and challenges of being 'with woman' in this context.

The journal *Midwifery* was selected for this article as it holds one of the higher impact factors (Impact Factor 1.98 for 2017) for the Field of Research of midwifery. Based in the United Kingdom (UK), this journal has an international readership. Consideration was given to the fact that models similar to the one described in this study are found within the UK, Canada, much of Europe and in many of the neighbouring Scandinavian Nations. In the short time since publication in January 2019, there has been considerable international interest in the findings of this research. There is keen interest in the newly – generated evidence around this

important phenomenon of being 'with woman' which has relevance to midwives working internationally in countries with a comparable maternity health care system. In addition to this, in many countries around the world, the 'unknown midwife' model remains the most prevalent within maternity systems. The findings of this research offer timely and contemporary evidence around the experience of being 'with woman' in the context of this model. Confirmation of adherence to copyright requirements is provided in Appendix J. Evidence of engagement with this research including a variety of metrics is displayed in Appendix K.

Reference

Bradfield, Z., Hauck, Y., Duggan, R. & Kelly, M. (2019). Urgency to build a connection: Midwives' experiences of being 'with woman' in a model where midwives are unknown. *Midwifery.* 69, 150 – 157.

Title: Urgency to build a connection: Midwives' experiences of being 'with woman' in a model where midwives are unknown

## Abstract

**Objective**: The objective of this study was to explore midwives' experiences of being 'with woman' in the intrapartum period within the context of an unknown midwife model.

**Design**: A descriptive phenomenological design was used with individual in-depth interviews. Transcribed interviews were analysed using thematic analysis that incorporated the data analysis framework offered by Amadeus Giorgi.

**Setting**: Hospitals within Western Australia providing intrapartum care to women where the midwife is not usually known to them.

**Participants**: Ten midwives were interviewed and recruitment ceased when data saturation was reached.

**Findings**: Findings confirm the importance of building a connection to enable partnership with the woman and provide woman-centred care that is inclusive of her partner. Factors influencing midwives' ability to be 'with woman' included the 'systems' approach to childbearing as well as common birth interventions prevalent within the public hospital system. Midwives experienced both rewards and challenges associated with being 'with woman' in the unknown midwife model, adaptability and self-awareness were features that enhanced the ability to be 'with woman' within this model.

**Key Conclusions**: Findings present new knowledge about being 'with woman', a phenomenon so central to the profession of midwifery, yet previously unexplored in the empirical domain. Insights gained reveal the intersection between the phenomenon and the unknown midwife model and highlight characteristics of the midwives that facilitate being 'with woman' such as adaptive expertise.

**Implications for practice**: Understanding the concept of being 'with woman' through the lived experience of midwives provides unique insight into the applied practices of the phenomenon. Characteristics of being 'with woman' as well as attributes and strengths demonstrated by the midwives provides important data for education and development of the profession. Explicating the challenges faced by midwives seeking to be 'with woman' in the unknown midwife model is useful for health leaders of service delivery and policy development to consider innovative ways to enhance this important practise advised by professional philosophy.

KEYWORDS

'with woman'; phenomenology; midwives' experiences; intrapartum; connection

## Introduction

Being 'with woman' (WW) is a central construct of the profession of midwifery (ACM, 2004). The importance of being WW as well as the characteristics of the phenomenon are embedded in the writings of peak midwifery professional bodies throughout the world including United Kingdom (UK)(RCM, 2014), United States (US) (ACNM, 2004), Australia (ACM, 2004) and New Zealand (Guilliland, 2010). The Australian College of Midwives' Professional Philosophy statement is prefaced by the following sentence "Midwife means 'with woman': this underpins midwifery's philosophy, work and relationships" (ACM, 2004, p. 1). The Professional Philosophy statement of the International Confederation of Midwives also asserts that the WW characteristic of working in partnership with women is a central feature of exemplary midwifery care (ICM, 2014).

Current understanding regarding the phenomenon of being WW is advised by theoretical writings from midwifery leaders and focusses on the importance of respectful relationships and working in partnership with the woman and her family (Fahy, 1998; Leap & Hunter, 2016). In the empirical domain, research exploring women's experiences of exemplary midwifery care has contributed to knowledge that reveals characteristics of the phenomenon such as partnership, woman-centred care, comfort and presence (Hildingsson, 2015; Hunter, 2002; Jepsen et al., 2017). Despite the centrality of being WW to the profession of midwifery, a recent literature review revealed that there is no research that explores the phenomenon from the perspectives of midwives (Bradfield, Duggan, et al., 2018).

Publically funded maternity care, typically provided in a fragmented fashion by a variety of health care professionals is a feature of maternity systems worldwide including Australia, Canada, New Zealand, the UK, the Netherlands (Hanafin & Emma, 2014), Japan (Torigoe, Shorten, Yoshida, & Shorten, 2016) and each of the Nordic Nations (Stig & Lutz, 2013). In Western Australia (WA), 58.6% of all births in 2013 were in a public hospital (Hutchinson & Joyce, 2016) compared with National figures in 2015 where this rate was 70% (AIHW, 2017). Current national data

collection focuses on the place of birth including public hospital, private hospital, birth centre or home (AIHW, 2018). Although place of birth data cannot reveal the model of care with accuracy, the vast majority of women birthing in the public hospital environment are cared for within traditional, fragmented models (AHMAC, 2011). Here, pregnant women are referred by their General Practitioner (GP) to attend antenatal care at their nearest public maternity hospital. Some services offer shared antenatal care with GPs but the majority will attend antenatal care at a hospital-based clinic where throughout their pregnancy, women receive care from midwives rostered on to a clinic that day as well as a variety of medical practitioners depending on the woman's clinical status (DOHWA, 2016). When presenting to the hospital in labour, women routinely receive care by midwives who are rostered to the birth suite with neither one necessarily having met before. During labour and birth, women receive medical attention only if their clinical condition warrants it (AHMAC, 2011). In this model, from the perspective of women, labour and birth care is provided by unknown midwives (UM).

In Western Australia, 2016 data showed that 63% of midwives were employed in the public sector (see Table 1). Because of the current limitations in data collection, it cannot be conclusively determined which model of care midwives are working in, only that they are employed by the government. Conservative estimates based on maternal data (Hutchinson & Joyce, 2016) and government reporting (AHMAC, 2011) suggest that the majority of these midwives are employed in the 'standard' fragmented model where labour and birth care is provided by an unknown midwife. To date, there is no data collection about models of care in the nationally required 'notification of attendance at birth' documentation (AIHW, 2018). Neither are there state or national figures on specific details of the model of care – only the place of birth and this may reflect the limited clarity on model definitions. The Australian Federal Government have recently completed a project considering the nomenclature for models of maternity care to facilitate consistency and data collection into the future (AIHW, 2014).

**Table 1. Registered and Employed Midwives - Western Australia**

| **Registered and employed midwives-locality specific** | | | | |
|---|---|---|---|---|
| Employment sector | 2013 | 2014 | 2015 | 2016 |
| Public sector only | 1,595 | 1,603 | 1,582 | **1,582** |
| Private sector only | 710 | 727 | 720 | 742 |
| Both | 68 | 74 | 62 | 60 |
| Non response | 248 | 186 | 215 | 206 |
| Total | 2,621 | 2,590 | 2,579 | 2,590 |
| Source: National Health Workforce Data Survey 2013-2016 (DOH, 2017) | | | | |
| Midwives include Midwife only, RN & Midwife, EN & Midwife, RN & EN & Midwife | | | | |
| Note the sector splits are based on clinical midwifery hours in public and/or private | | | | |

The predominance of the publically-funded, fragmented model (referred to as 'standard' maternity care) sees it placed as the setting for much of the research conducted in the maternity sector. Research has focussed on comparing the UM model with continuity models where women are cared for by known midwives (Tracy et al., 2013; Tracy et al., 2014; Wong, Browne, Ferguson, Taylor, & Davis, 2015). Findings show that the UM model is associated with an increased caesarean section rate and higher health costs (McLachlan et al., 2012; Tracy et al., 2014) as well as higher epidural, episiotomy and instrumental birth rates; and lower rates of maternal satisfaction (McLachlan et al., 2016; Sandall et al., 2016). Theoretical writings from midwifery leaders reveal the challenges faced by midwives when providing woman-centred cared in the context of a medically-dominant model and reiterate the importance of midwifery philosophy and identity to underpin midwifery practise (Brodie & Leap, 2008; Fahy & Parratt, 2006; Kirkham, 2004; Leap & Hunter, 2016). There has been no research to date that has explicitly sought to understand the phenomenon of being 'with woman' from the perspective of midwives. Our study aimed to explore midwives' experiences of being WW during labour and birth specifically in the context of the UM model.

## Methods

### Design

This study used a descriptive phenomenological design to explore the lived experience of midwives being WW during the intrapartum period in the context of the UM model. The genesis of the design is found in Husserl's Philosophy of Phenomenology which involves the thoughtful and methodological process of exploration with a phenomenological attitude as opposed to a 'natural attitude' (Berndtsson et al., 2007). The researcher's phenomenological attitude is characterised by an openness toward the phenomenon under study which facilitates rich descriptions and revelation of the constituents of the phenomenon as experienced by different individuals. Descriptive phenomenological research is useful to gain an understanding of the 'lifeworld' of participants and examine the same phenomenon as it reveals itself to individuals (Matua & Van Der Wal, 2015). Giorgi (1997) offered one of the earliest frameworks to scaffold the phases of phenomenological research; his approach is utilised in this study (Giorgi, 1997). This research was approved by Curtin University Human Research Ethics Committee (HREC) (approval number HREC 2016 - 0450).

### Participants

Midwives who had provided labour and birth care to women in publically-funded 'standard' models within the last 12 months were recruited. The midwives recruited from this model routinely provided care to women randomly assigned to them on their rostered shift. In this way, care was provided by an unknown midwife (UM). On "rare occasions" , midwives in small rural centres may 'know' the woman they provide intrapartum care to but this would be coincidental, would not have meant that pregnancy care was provided by this midwife and was more likely a result of co-habitating in a small community  not because the model arranged care by a known midwife. The study was advertised at a local midwifery conference attended by over 170 midwives where participants were purposively sampled to ensure

thorough capture of the phenomenon. Midwives who expressed an interest were contacted for data collection. Further recruitment occurred through the process of snowballing, which proved to be an effective method of connecting the researcher to participants who have a lived experience of the phenomenon (Whitehead et al., 2016b). Prospective participants were emailed an information letter and written, informed consent was obtained prior to interview. Ten female midwives participated: their ages ranged from 35 to 62 years and they had between 5 and 35 years of midwifery experience. Level of midwifery education and countries practiced in varied; some participants had previously worked in continuity of care models and one had prior experience in a private obstetric model. In total, seven health services were represented, and two of the participants were employed in separate rural public hospitals. A demographic profile is presented in Table 2.

**Table 2. Demographic Profile (n= 10)**

| Demographic variables | Number of participants |
|---|---|
| Age | |
| 30 to 40 | 2 |
| 41 to 50 | 2 |
| 51 to 60 | 5 |
| 61 to 70 | 1 |
| Years of experience as a midwife | |
| < 5 years | 2 |
| 5 to 10 years | 1 |
| 11 to 15 | 1 |
| 16 to 20 | 1 |
| 21 to 25 | 4 |
| 26 to 30 | 1 |
| Level of midwifery education | |
| Hospital – based diploma | 5 |
| Undergraduate midwifery degree | 1 |
| Postgraduate midwifery qualification | 4 |
| Countries practiced midwifery | |
| England | 2 |
| Scotland | 1 |
| New Zealand | 1 |
| Previous midwifery model | |
| Midwifery-led continuity | 5 |
| Unknown midwife, known obstetrician | 1 |
| Total | 10 |

## Data Collection

In depth interviews were conducted at a location and time convenient to the participants, digital audio recordings were transcribed verbatim. Participants were asked to describe their experiences of being WW during labour and birth and to

reflect on any intersection between being WW and working within the UM model. The opening question was "would you describe your experiences of being 'with woman' in the context of the model of maternity care that you're working in?" Adopting the phenomenological posture of deliberate naiveté (Bevan, 2014), the researcher followed the accounts of participants which prompted questions that provoked deep and rich descriptions. One to one interviews lasted between 45 and 90 minutes; eight were conducted face-to-face and two by telephone to accommodate the inclusion of midwives working in rural hospitals in regional areas.

The interviewer, a midwife academic, was known to three of the participants as past professional acquaintances. The potential for influence on participants' responses was considered minimal as the researcher had worked with only one of the midwives for a short period over 5 years ago. The researcher was cognisant of adopting a neutral tone of voice and body posture so as not to influence responses (Giorgi, 1997). The process of bracketing is critical to the phenomenological process. This involved suspension of the researchers' personal assumptions or prior conceptualisations of being WW which provoked immersion in the participants' 'lifeworld' through their descriptions of their lived experience of the phenomenon (Giorgi, 1997, 2012). Strategies to enhance phenomenological reduction included; recording of the first author's assumptions about being WW prior to data collection; maintenance of field notes; research journaling to reduce any pre-existing thoughts and to facilitate reflection post- interview (Ortlipp, 2008); and regular meetings with the research team. Midwives were offered the opportunity to provide additional comments after the conclusion of the interview, one did this by email and another by telephone which was recorded and transcribed. Data saturation became evident after seven interviews, however a further three interviews were conducted to confirm no additional or new concepts (Fusch & Ness, 2015).

### Data Analysis

Data analysis was iterative and guided by Giorgi's four stage phenomenological approach: 1) data immersion, facilitated by the primary researcher conducting the interviews and reading the transcripts while listening to the audio recordings; 2) dividing data into concepts where individual 'meaning units' or conceptualisations were extracted. Grouping and management of the qualitative data was facilitated by the use of data analysis software N-Vivo® (version 11); 3) organisation and transformation of the data, arrangement and expression of the data - where commonality in midwives' descriptions revealed the essences of the phenomenon; and finally; 4) expressing the constituents of the phenomenon as the researcher's disciplinary intuition was used to transform statements into concepts expressing the constituents of the phenomenon(Giorgi, 1997). These constructs were supported by direct quotations. For clarity and brevity, non-essential words within quotes were omitted and are indicated by an ellipsis (…), where words have been inserted to provide conversational context, non – italicised words appear in square brackets [ ] (Whitehead et al., 2016b). Quotes that support themes and subthemes are presented in italics with a unique identification code (P1 to P10). The first author analysed all transcripts which were also analysed separately and concurrently by at least one other member of the research team. Initial findings were conferred until a consensus was reached which added rigor to the analysis. Any discrepancy was resolved by consulting the transcripts ensuring credibility and trustworthiness (Giorgi, 1997, 2012).

## Findings

Three common themes arose from the data 1) Building a Connection; 2) Influences of the UM model on being WW; and 3) Rewards and Challenges of the WW Connection for Midwives. Themes and corresponding sub-themes are presented in Figure 1.

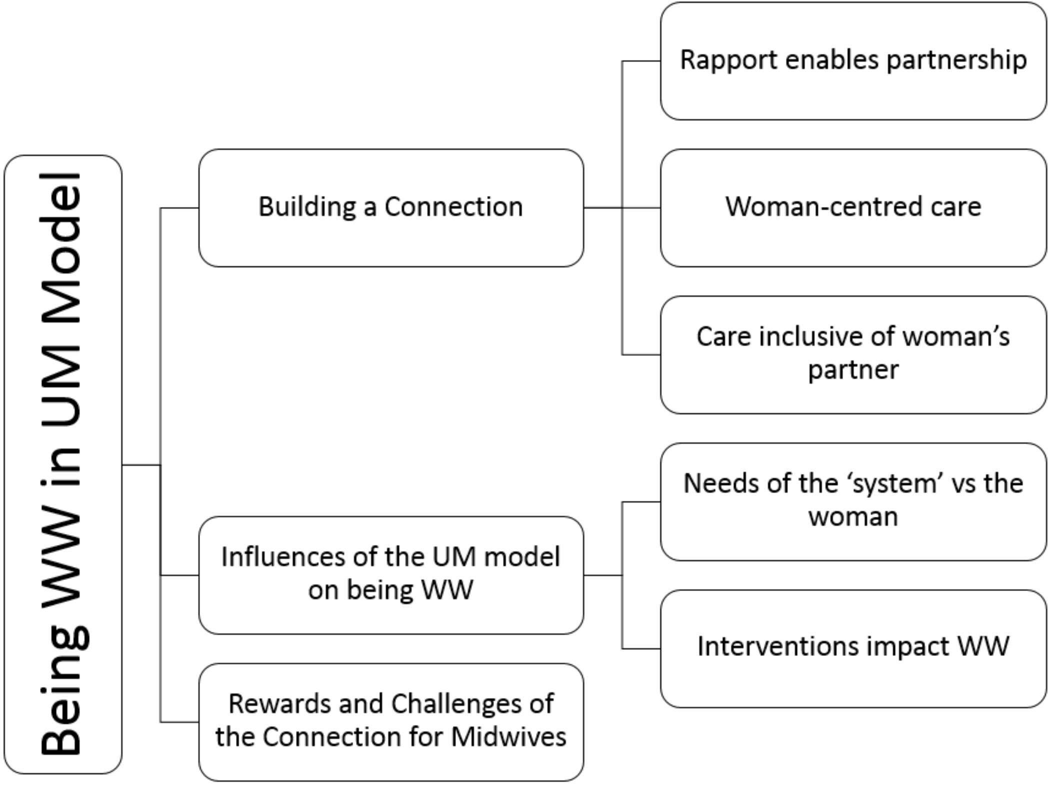


**Figure 1. Themes and Subthemes: Midwives being 'with woman' (WW) in the Unknown Midwife (UM) Model.**

## Building a Connection

The importance of building a connection with the woman was woven throughout the midwives' descriptions of being WW in the UM model. Midwives demonstrated skilled expertise in developing a rapport that enabled partnership with the woman, which placed her at the centre of her care and was respectful and inclusive of the woman's partner.

### Rapport enables partnership

The first theme revealed the significance of building a connection with the woman. Midwives described the importance of building rapid rapport with the woman who in most cases they had not met before: *we're very good at quickly getting to know somebody and building up a rapport …you can give her amazing support by doing*

*that* (P5). The act of respectfully listening and hearing what the woman wants enabled the rapid rapport and built trust which facilitated a relationship or partnership with the woman: *those kinds of basic things to make them feel comfortable that they then start to trust you and then you can build the relationship* (P7). Developing a respectful and trusting partnership with the woman enabled the midwife to provide intuitive care responsive to the woman's needs: *I'm looking for her actions, the way she's moving and that varies from being really subtle to* [more] *obvious movement, verbal intonation, making sounds, voicing or she could be talking to herself and I'm still listening to what she's saying* (P8) These intuitive skills provided feedback to the midwife on the supportive strategies that the woman might need: *very quickly I will judge whether the woman wants me to touch her* (P10).

Factors unique to the woman also influenced midwives' ability to build a rapport. For example, when the woman presented for care, especially if she was in established labour and preoccupied with the overwhelming physical process: *because you don't know them and, that's the first time you're meeting them particularly if you're meeting them in, good labour and in pain, how do you get to know them* (P7). Another midwife added strategies for meeting women in established labour and emphasised the potential to be WW at any stage with the right skills:

*Sometimes you turn up at a very difficult time for a woman so it's very difficult to gain that* [connection] *straight away. It's not impossible with the right tone of voice, with the right words spoken, with the right respect given, all of that is possible… to be with woman* (P4).

#### Woman – centred care

Forming a trusting partnership which fostered intuitive ways of being WW enabled midwives to offer individualised woman-centred care: *to be with woman you're totally committed to her for that time when she's in labour* (P5). Midwives emphasised the importance of developing an open posture that recognised the

unique needs of each woman: *being open to the fact that women will labour and birth differently every woman is different* (P2). This approach also required flexibility on the part of the midwife: *you need to consider* [women] *individually and get that connection with that woman… you can just sort of adapt to that woman in that situation at that time* (P4).

Putting the woman at the centre of care in the UM model required midwives to provide advocacy and empowerment which were described as important attributes of being WW. Midwives relayed the powerful effect that advocacy and empowerment had on ameliorating some disempowering features of the medical model and refocusing attention to the woman's needs:

*I've got more of a battle on my hand to be with woman … if the woman wants a vaginal birth then I will try and facilitate that at all costs within safety … if you've got an obstetrician for the first sign of an issue that they're going to persuade the woman for a Caesarean section,* [that] *makes you work harder* (P10).

Another midwife characterised how she used her rapport and partnership to offer support and encouragement to the woman which facilitated her self-determination:

*…the doctor kept going in and doing the negatives… "This baby's OP I don't think you'll do this… last time you ended up a Caesarean". So I then would go in, "you're so well, look at you, how quickly you've progressed" just trying to counteract some of that negativity…* (P5).

### Care inclusive of the woman's partner

Another feature of the midwife-woman connection was acknowledging and including the woman's partner: *it's really important to include them* [partners] *so that they can understand and feel part of the deal* (P4). Midwives being sensitive to the woman's relationship with her partner was recognised as part of being WW and helped the midwife to respect the relationship between the woman and her partner to consider what support might be provided by the partner and/or required

by the midwife: *I'm watching her, the way she tracks with her partner…to see whether I need to further engage with her…or I need to provide some more verbal support or just some physical support to her* (P8).

## Influences of the Unknown Midwife Model on Being 'With Woman'

Midwives reflected on factors which influenced being WW including the organisational structures of the health environment. Midwives demonstrated resilience and determination to be WW in spite of the challenges often at a cost to themselves.

### Needs of the 'system' vs the woman

Midwives described factors unique to the UM model that intersected with the practice of being WW. Systems-based influences including workload allocation within birth suite was referred to as a factor that impacted being WW. To illustrate, midwives were allocated to care for women according to the needs of the organisation rather than the needs of individual women:

*…it would be nice if you were allocated, you stay with that person the whole of your shift; that would make a big difference … But circumstances change and you then you have to move here and move there and come in and out …* (P3).

Midwives were often required to care for more than one labouring woman at a time, covering meal breaks and adjusting to staffing needs which presented a challenge to forming a connection with the woman:

*You can try very hard to be with woman but you can then constantly be pulled in ten different places … If you've got a woman who doesn't directly need your hands on attention right this second… you can get pulled out then you get moved. So women can actually see a few midwives while they're trying to rejig skill levels and staffing and breaks* (P6).

Shift changes that were dictated by strict rostering rather than the woman's need meant that midwives were often required to leave a woman during her labour: … *leaving someone in the middle of labour is, it's terrible, it's not a good thing* (P9).

Midwives cited the medical model, dominant in the hospital environment, as influencing being WW, where labour care is provided by an unknown midwife. The 'systems' approach to the 'efficient throughput' sees fragmented care of women through the childbearing process. Midwives have reported that the model, founded in historically hierarchical and paternalistic structures, produces a disconnect and is disempowering of women:

*…then you get the obstetricians who are incredibly controlling and egotistical because the plans of care they want to enforce don't seem to have anything to do with the woman or evidence it just seems to be "this is what I want to do "…who think it's appropriate to just shout what they want at you … sometimes you can have this big fight literally to get a bit of evidence based care, to get the woman more time or more space* (P6).

Reflections were shared on how the model intersects with the physical hospital environment, characterised by a lack of privacy, routine monitoring, standardised policies and interventions: *…the environment plays a big part as well and the fact … they're medicalised the minute they walk in the place really… It's very difficult because it's just so against our natural mammalian instincts to be in that environment to start with* (P3).

Another feature of the model is the fragmented care provided which influences being WW: … *you don't know anything about them* [women] *so you have to, in your own practice develop a system of how you can interact and work with a different woman every day that you go to work* (P7). Midwives reflected on the impact of fragmented care:

*... they [women] come to the antenatal clinic and see a different midwife every time and then they don't see that midwife up on labour and birth suite, an awful lot of*

*women don't really know what's going to happen, scared, "I'll have an epidural" and there's no confidence in themselves* (P5).

In contrast, midwives working in smaller, rural or secondary hospitals noted that one to one care in labour was more common and there was the occasional possibility that the midwife may have met the woman antenatally even in passing which facilitated trust: *…occasionally a woman that I've seen in clinic* [might present] *in labour... the minute you walk in she kind of goes "oh it's you!" … she trusts you… it's more fortuitous than a regular occurrence* (P5).

### Interventions impact being WW

Women who requested intervention during labour and birth altered their needs for support and their ability to connect with those around them. One participant revealed the contrast in this regard:

*…when I look after women, who have no pain relief who birth standing up, that is just magical. Compared, to if I had a woman who has an epidural and Synto* [syntocinon] *it is so different because you are not interacting through every single contraction you know empowering her, telling her this is normal, you can do this* (P1).

Another midwife added ways that midwives could apply supportive WW practices in such circumstances:

*… lots of clinical stuff happening like epidurals, syntocinon … it's quite different because, but you're still with woman because she's still going through the journey of labour and in birth… you're giving explanations and performing clinical investigations like examinations and palps, lots of documentation … which can distract you from [providing] all the psychological, emotional support that she needs* (P9).

Having the midwife present and staying in the room was seen as an important antidote to the detachment that might occur when women have birth interventions

as seen in this midwife's description of WW care: *you would see me sitting by the side of the bed, notes on my knee and I would be dictating what I'm writing to women… that would be being with woman… you'd see sharing, communication and interaction that's constantly present* (P10). Another midwife offered an example of how interventions during labour can actually be viewed as facilitating a midwife being WW: *the only time you can actually be with woman is if* [if the woman has] *epidural synto* [syntocinon] *you can't get out the room, so you can actually sit with the woman and you're spending time with the woman* [whilst] *filling out charts* (P6).

## Rewards and Challenges of the Connection for Midwives

Midwives reported that being WW in the UM model had a significant impact on them. Building connection with women and their families by being WW meant that midwives shared the range of emotions expressed by the women. The personal impact of having these connections was revealed in descriptions where professional and personal roles were entwined: *…it's not all happy* [or] *all sad…it has its ups and downs, but I just love it… being* [with woman] *in that intimate environment, it stays in there forever. It makes me, it's my life and is not a job to me* (P1).

In order to meet the individual needs of women, midwives described the need to be flexible and adapt their 'ways of being' WW and develop a connection demonstrating self-awareness and reflexive practice:

*… being able to adjust myself and adjust my interactions with women, my intuitions. I have to listen to it very carefully and sometimes, a downside is that I might not listen to it as carefully if I don't know this woman. I may not trust myself as much if I don't know this woman, I might be more on guard… if I'm working in this model then I have to have the skills… I feel like I can be just as much of a midwife to a woman that I don't know, it may be different but it's still a woman who needs me as a midwife in the shape that she needs me as a midwife* (P8).

Participants reflected that being WW provided challenges too: *you invest emotionally, it's exhausting* (P2). Midwives were aware of the intersection of their

professional role with their personal lives and reconciled that being WW required them to bracket any private issues and selflessly and intentionally choose to be WW: *It costs emotionally, physically… you have to go to work knowing it's going to, you have to leave your baggage at the door and you have to go into work and be present* (P10).

Midwives were emphatic about the necessity of being WW by asserting the inextricable link between being a midwife and being WW: *You couldn't do your job without being with woman… that's the foundation, that is the primary role and then you start to do all the* [other] *midwifery stuff,* [being WW is] *very, very important* (P7). Another midwife also shared insight into the fact that being WW was not a practice that came naturally to all midwives but offered that it could be developed: *that's why I do midwifery that's why wanted to do it the ability to be with woman… while* [being WW is] *naturally intuitive to some midwives,* [it] *only comes with experience and confidence for others* (2).

## Discussion

Based on the findings, the discussion focuses on the key concepts considered within existing literature. Our findings confirm the importance of being WW to the practice of midwifery care of women during labour and birth and reveals attributes and skills of the midwives as well as challenges experienced in the UM model.

The skilful and rapid way in which midwives developed a rapport which enabled a partnership with the woman that was inclusive of her partner is presented as the core component of being WW in the UM model. Midwives' descriptions confirmed the need to be adaptable and responsive to what individual women needed. In a Delphi study exploring 'exemplary midwifery practice', Kennedy (2000) reported that midwives' ability to intuit the care required by women was based on their expert skills of forming a connection with the woman(Kennedy, 2000). A commentary authored by several international midwifery leaders reiterated the importance of developing connection with the woman and added that this required

skill on behalf of the midwife and enhanced midwifery practice (Hunter et al., 2008). The importance of connection was also confirmed in ethnographic research conducted with 11 Icelandic midwives revealing that building relationship with the woman was important to both women and midwives; which contributed to an enhanced knowledge of the woman and safer practice (Ólafsdóttir, 2006). The expert skills of the midwives in our study revealed their ability to adapt to what the woman needed and was an essential feature of being WW that was interwoven throughout the themes.

Adaptability is the focus of emerging research and discussion in the health arena. The concept of the adaptive expert was originally introduced by developmental psychologists Hatano and Inagaki in 1984 (Hatano & Inagaki, 1986) and has been applied to diverse disciplines such as education (Timperley, 2013) and engineering (Larson, Lande, Jordan, & Weiner, 2017). Adaptive expertise is defined in relation to its counterpart, the 'routine expert'. Routine experts are able to demonstrate high-level abilities and skills in a context and manner that is predictable and routine. Adaptive experts however are able to perform at expert-level under changeable circumstances and are characterised by an ability to create unique and individualised ways of responding in dynamic circumstances. In the education context, it is contended that teachers who are adaptive experts 1) have a moral imperative to provide a student-centred experience, 2) provide agency for the purposes of 'making a difference'; and 3) possess self-awareness that enhances effectiveness (Timperley, 2013; Timperley, Ell, & Deidre, 2018). The similarities between the adaptive expert and the attributes and descriptions from midwives in our study are apparent. Midwives demonstrated their ability to adapt their approaches to be with the woman in the way that was needed. Adaptability is evident in the stories of midwives' whose primary focus was to expertly build connection with the woman under potentially challenging circumstances. Placing the woman at the centre of her care was an attribute of being WW as was including the woman's partner. The skill of providing individualised care in the context of an environment that favours standardisation over woman-centred care was clearly

evident. Midwives also reflected on the personal impact of being WW and demonstrated self-awareness along with adaptability as important attributes that facilitated being WW.

In the field of medical education, it is asserted that having adaptive expertise is essential for modern health professionals who must be able to 'think outside the square' and adapt to the frequently changing health landscape (Cutrer et al., 2017; Mylopoulos & Woods, 2017). In a recent editorial, it was asserted that adaptive experts offer the antidote to increasing 'protocolisation and standardisation' of health systems. The authors, medical educators, add that clinical guidelines and protocols provide advice that is generalised and may be inappropriate for health needs of an individual. It is asserted that adaptive expertise, facilitates identification and reframing of the health presentations not best served by a standardised approach and uses applied knowledge and understanding to provide care that is evidence based and individualised (Cutrer & Ehrenfeld, 2017).

Midwives in our study described features of the UM model that intersected with their ability to be WW. Staffing according to institutional efficiency rather than on individual women's needs resulted in interruptions to the practices of being WW. Our findings are supported by research conducted in Australia where 22 midwives, revealed factors including time constraints found within the staffing models of the public health system and increasing surveillance impacted on midwifery care(Carolan-Olah, Kruger, & Garvey-Graham, 2015). The hospital environment has become synonymous with frequent interventions and monitoring as well as a standardised approach to policies and practices (Jenkinson, Kruske, & Kildea, 2017) . A recent ethnographic study conducted in Australia with 16 women and midwives found that midwives experience conflict when seeking to provide woman-centred care in an environment that requires midwives to prepare women for 'system requirements' (Newnham, McKellar, & Pincombe, 2017) .

Being WW in the UM model impacted midwives professionally and personally. Descriptions revealed the interconnectedness between the person and profession

of the midwife. Midwives described adapting to the highs and lows with the women that they cared for and reflected on the challenges and costs to being WW in the UM model. Our qualitative findings are further supported by recent research with 862 Australian midwives which found those working in fragmented models (n=648) scored higher on scales rating burnout, anxiety and depression than their counterparts working in continuity models (n=214) (Fenwick et al., 2018). Midwives in our study considered the 'cost' of the connections built in the process of being WW and described features that sustained them such as adaptability and self-awareness. Our findings are also supported by research undertaken with 11 UK midwives exploring features that enhanced or diminished their professional resilience; which confirmed midwives' ability to be flexible and self-aware enhanced their resilience (Hunter & Warren, 2014).

## Strengths and Limitations

A strength of this study includes the collection of data from midwives currently working in a variety of public hospitals around Western Australia including rural and remote areas. Midwives self- selected which may suggest that they hold distinctive views about being WW and cannot be regarded as representing all midwives working in this model of care. Although practices may differ between other states and countries, the demographic details provided as well as the richness of the data facilitates consideration of transferability of the findings to other models of care or maternity settings.

## Conclusion

Findings offer new knowledge surrounding a phenomenon of being 'with woman' which is central to midwifery and had not previously been explored. The intersection between the phenomenon and the UM model has revealed the expert skills of the midwives who build connection with women to provide woman-centred care in a hospital environment that presents challenges to being WW during labour and birth. Within the UM model, characteristics such as self-awareness and

adaptive expertise facilitate midwives to be WW in the context of a dynamic and challenging environment. Highlighting the strengths and attributes of these midwives as well as drawing attention to the challenges experienced, provides the opportunity for service providers, educators and policy-makers to explore innovative ways to facilitate the important professional imperative for midwives to be 'with woman'.

HIGHLIGHTS

- Midwives in the UM model strive to build a crucial connection and rapport that facilitates partnership and woman-centred care  inclusive of the woman's partner
- The 'systems' approaches evident in fragmented care and increased interventions within the UM model challenges midwives being 'with woman'
- Adaptability and self-awareness are central features enabling midwives to be 'with woman' in the 'unknown midwife' model

## Chapter Conclusion

This chapter has presented the final published manuscript detailing the exploration of midwives' experiences of being 'with woman' in the context of the unknown midwife model. The next chapter addresses the study objective of exploring midwives' experiences of being 'with woman' in the context of the private obstetric model where labour and birth care is provided by unknown midwives and known obstetricians.

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# Chapter Seven • Midwives' Experiences of Being 'With Woman' in the Private Obstetric Model

## Chapter Introduction

This chapter contains the final manuscript of an article which was accepted and published in Women and Birth Journal. The manuscript addresses the study objective of exploring midwives' experiences of being 'with woman' in the context of the private obstetric model where care is provided by an unknown midwife and a known obstetrician (UMKO). A unique feature of the two-tier health system in Australia, childbearing women who are privately insured and with financial means, may elect to receive private obstetric care in the antenatal and intrapartum periods.

Midwives working in the UMKO model described unique experiences of being 'with woman' distinctive from those offered by midwife participants working in other models. The findings revealed that the triad of relationships which formed between the woman, midwife and obstetrician was important and influenced midwives' being 'with woman'. Midwives' descriptions of the intersection between the phenomenon and the UMKO model revealed features that both enabled and challenged midwives' 'with woman' practices. Finally, midwives offered insight into the impact that being 'with woman' had on them within the context of this UMKO model.

The journal Women and Birth was selected for this article as it holds one of the highest impact factors (Impact Factor 1.82 for 2017) for the Field of Research of midwifery. The private obstetric model in Australia is unique and replicated similarly in only a few other Organization for Economic Cooperation and Development (OECD) nations in the world (OECD, 2018). Despite being a renowned international journal and leading publisher in this field of research, Women and Birth is also the official Journal of the Australian College of Midwives. It was considered that both the Australian and international contingent of readers would be interested in the findings of this important research that addresses a significant gap in knowledge not only about the phenomenon of being 'with woman' but

also reveals new information about a model that has traditionally been difficult to access and research. Fulfilment of the copyright requirements is confirmed in Appendix L. There has been considerable interest in the findings of this paper which has been presented at a National Conference. Other evidence of engagement with this research including article downloads and requests for access are shown in Appendix M.

Reference

Bradfield, Z., Kelly, M., Hauck, Y., & Duggan, R. (2018). Midwives 'with woman' in the private obstetric model: Where divergent philosophies meet. *Women Birth*. doi:10.1016/j.wombi.2018.07.013

Midwives 'with woman' in the private obstetric model: where divergent philosophies meet

## Abstract

**Background:** The phenomenon of being 'with woman' is central to the profession of midwifery. There is currently no available evidence that explicitly explores this phenomenon. In Western Australia, over a third of childbearing women choose to engage the services of a private obstetrician who provides antenatal care and manages the care provided by midwives during labour and birth.

**Aim:** The aim of this study was to explore midwives' experiences of being 'with woman' during labour and birth in the private obstetric model.

**Methods:** Using a descriptive phenomenological approach, 11 midwives working in the private obstetric model in Western Australia were interviewed. Data analysis was conducted using Giorgi's framework.

**Findings:** Two main themes emerged 1) triad of relationships and 2) the intersection between being 'with woman' and the private obstetric model; seven subthemes are reported.

**Discussion:** Being 'with woman' is an important element of midwifery practice and fundamental to midwifery theory and philosophy. Relationships between the woman, midwife and obstetrician are key to implementing 'with woman' practices in the private obstetric model. The interrelatedness of midwifery philosophy and practice is revealed through shared common challenges and enablers to being 'with woman' from the perspective of midwives.

**Conclusion:** Findings offer insight into midwives' experiences of being 'with woman' within the context of the private obstetric model. New understandings are revealed of a phenomenon central to midwifery professional philosophy that is embedded within midwifery practices which has implications for service mangers, professional leaders and educators.

Keywords

Midwifery; 'with woman'; private obstetric; philosophy; midwifery practice; professional identity

Statement of Significance

Problem

Being 'with woman' is central to midwifery philosophy. Currently, there is no evidence about how the midwives experience the phenomenon of being 'with woman' and how or if this intersects within different models of care.

What is already known

Being 'with woman' is central to midwifery philosophy and underpins midwifery practices worldwide.

What this paper adds

New knowledge about the intersection of midwifery philosophy and practice in the context of the private obstetric model in Western Australia.

## Introduction

Midwives being 'with woman' (WW) is a central construct of the profession of midwifery(ACM, 2004). The importance of being WW is referenced in key midwifery writings across the world including the United Kingdom (UK)(RCM, 2014), and New Zealand (NZ) (Guilliland, 2010). The Professional Philosophy statement developed by the Australian College of Midwives supports this construct which is prefaced by the statement "Midwife means 'with woman': this underpins midwifery's philosophy, work and relationships" (ACM, 2004, p. 1). Further, being WW is incorporated into the Australian midwifery professional code of conduct and standards for practice (NMBA, 2008, 2018).

The importance of the woman-midwife relationship, to the applied practices of being WW has been emphasised in previous writings (Leap, 2009; Leap & Hunter, 2016; Page, 2003). Being WW by working in partnership with women is the central theme of the professional philosophy statement set by the International Confederation of Midwives (ICM, 2014). Much of what is currently understood about the phenomenon of being WW is derived from midwifery leaders' theoretical contributions (Fahy, 1998; Leap & Hunter, 2016). Research exploring women's experiences of midwifery care has been used to describe what characterises midwives' WW practices and includes attributes such as advocacy, partnership, caring that is woman-centred, comfort, presence and guidance (Hildingsson, 2015; Hunter, 2002; Jepsen et al., 2017). The presence of a midwife providing support, encouragement and guidance within the physical, emotional and psychological domains is valued by women and seen as the essence of being WW (Hunter, 2009; Jordan & Farley, 2008).

Despite the centrality of the phenomenon to the philosophical and practical work of midwifery, a recent literature review revealed that there is no existing evidence to confirm how midwives themselves perceive the phenomenon of being WW (Bradfield, Duggan, et

al., 2018). It is for this reason that the phenomenon warrants exploration, giving consideration to how the models of maternity care intersect with the practice of being WW.

Maternity care in Australia is provided within a two-tier system of public and private service models. In the state of Western Australia (WA), women may choose to receive maternity care through a public hospital or publicly funded continuity of care program; or homebirth with a privately practicing midwife. Those with private health insurance may choose private obstetric care(DOHWA, 2017b). The state of WA has the highest uptake of private obstetric care in Australia. The most recent data from 2015 showed that over 40% of pregnant WA women chose to receive maternity care under the private obstetric model compared with a national average of 27% (AIHW, 2017). Women are referred by their general practitioner to an obstetrician of their choice. Women consult with the obstetrician within the first trimester and then participate in follow up appointments throughout their pregnancy. In this model, antenatal care is conducted by the obstetrician and in some instances, in conjunction with midwives employed to work in the obstetrician's office (DOHWA, 2016). Women may also attend antenatal classes offered by midwives in their selected private hospitals. Aside from these classes however, women rarely engage with midwives at the respective hospital until labour commences or is induced (DOHWA, 2017b). In this model, midwives are employed by the private hospital and provide care to the woman under the direction of the chosen obstetrician who has been privately contracted by the woman. In this way, women receive care during their labour and birth by unknown midwives but known obstetricians (UMKO).

The difference between this UMKO model and the alternative publically funded obstetric led model in WA is the woman's choice. In the publically funded model, women may receive care in labour by an unknown midwife but will only receive obstetric care if necessary; and by an obstetrician on call with whom the woman has no prior relationship. The public sector also offers midwifery group practices where a professional relationship develops between the midwife and the woman, although these practices are relatively limited the trend is increasing (Homer, 2016). In the UMKO model, the pregnant woman selects, contracts and is cared for solely by her chosen private obstetrician, however during labour she is also cared for by a hospital midwife rostered in birth suite.

There is no research that explores the experiences of any of the stakeholders of private obstetric care where women choose and pay for primary obstetric care from early pregnancy through to birth during which time the woman and her obstetrician develop a relationship. This differs from the public obstetric model where women routinely receive midwifery care and only see an obstetrician if a clinical condition warrants review, obstetricians are usually not known to the women and care is covered under the government-funded Medicare scheme. Over a third (34%) of the WA Midwifery workforce is employed within the private obstetric model (including those who work in both public and private sectors) as shown in Table 1 (National Health Workforce Data Sets (DOH, 2017)). Despite the significant participation of midwives in private obstetric models, there is no evidence about how working in this model impacts midwives' ability to be WW during labour and birth, or how the model intersects more broadly with the profession of midwifery.

**Table 1. Registered and Employed Midwives-Western Australia**

| **Registered and employed midwives-locality specific** | | | | |
|---|---|---|---|---|
| Employment sector | 2013 | 2014 | 2015 | 2016 |
| Public sector only | 1,595 | 1,603 | 1,582 | **1,582** |
| Private sector only | 710 | 727 | 720 | 742 |
| Both | 68 | 74 | 62 | 60 |
| Non response | 248 | 186 | 215 | 206 |
| Total | 2,621 | 2,590 | 2,579 | 2,590 |
| Source: National Health Workforce Data Survey 2013-2016 (DOH, 2017) | | | | |
| Midwives include Midwife only, RN & Midwife, EN & Midwife, RN & EN & Midwife | | | | |
| Note the sector splits are based on clinical midwifery hours in public and/or private | | | | |

Research to date regarding the private obstetric model is from Australia and Ireland and has focussed on outcomes for women. For example, evidence confirms that the rates of obstetric intervention throughout the childbearing continuum are higher in this model compared to publicly funded obstetric led models (Dahlen et al., 2012; Lutomski, Murphy, Devane, Meaney, & Greene, 2014) and midwifery led models (Tracy et al., 2014) .

Theoretical writings primarily discuss the challenges faced by midwives who work from a midwifery philosophy that values birth as a physiological event, within the context of care offered in publically funded obstetric led models (Brodie & Leap, 2008; Fahy, 2007; Fahy & Parratt, 2006; Kirkham, 2004; Leap & Hunter, 2016). Given this gap in knowledge around the phenomenon of being WW our study aimed to explore midwives' experiences of being WW during labour and birth in the context of the UMKO model in WA.

## Methods

### Design

The study used descriptive phenomenology which has its genesis in Husserlian philosophy. Phenomenological research seeks to understand phenomena by exploring the lived experience of participants in a way that reveals the necessary features and meanings of the phenomenon under study (Whitehead et al., 2016b). The methodology is characterised by the epistemological stance of phenomenological reduction where the researcher is called to bracket prior knowledge and develop an openness to the 'lifeworld' of the participants through their description of the phenomenon (Finlay, 2013). This study employed Giorgi's (1997) framework for descriptive phenomenological research which focuses on describing the same phenomenon as it manifests itself to different individuals. The commonalities in participants' descriptions reveal essences and meanings of the phenomenon (Giorgi, 1997; Husserl, 2012). Descriptive phenomenology is an ideal methodology to gain insight into the applied practices, perceptions and experiences of being WW from the perspective of midwives working in the UMKO model as it uncovers constituents of the phenomenon not conceptualised by prior research (Finlay, 2013). This study was approved by Curtin University Human Research Ethics Committee (HREC) (approval number HREC 2016 - 0450).

### Participants

Participants were midwives employed at four of the five Perth metropolitan private obstetric hospitals who were involved in providing intrapartum care to women in labour and birth suite. The inclusion criteria were midwives who had provided labour and birth care to women within the private obstetric model in WA in the last 12 months to mitigate recall

bias. Recruitment commenced with the study being advertised at a local WA midwifery conference and midwives who volunteered were purposively sampled to ensure that the phenomenon under study was captured Some midwives indicated their interest in participating which led to a process of snowballing and further recruitment. Snowball sampling is an accepted and effective method of connecting the researcher to potential participants who have a lived experience of the phenomenon under study (Whitehead et al., 2016b). Interested midwives were emailed an information letter and informed consent was obtained prior to interview. Eleven female midwives participated in an interview, their ages ranged from 32 to 56 years and they had between 3 and 31 years of midwifery experience. Some participants had previously worked in public hospitals where labour and birth care was provided by an unknown midwife. None had previously worked in continuity of care midwifery models. A demographic profile of participants is presented in Table 2.

**Table 2. Demographic Profile of Research Participants (N=11)**

| Demographic variables | Number of participants |
|---|---|
| Age | |
| 30 to 40 | 5 |
| 41 to 50 | 2 |
| 50 to 60 | 4 |
| Years of experience as a midwife | |
| < 5 years | 2 |
| 5 to 10 years | 3 |
| 11 to 15 | 2 |
| 16 to 20 | 0 |
| 21 to 25 | 0 |
| 26 to 30 | 2 |
| 31 to 35 | 2 |
| Midwifery education | |
| Hospital – based diploma | 4 |
| Undergraduate midwifery degree | 2 |
| Postgraduate midwifery qualification | 5 |
| Country of midwifery education | |
| Australia | 10 |
| United Kingdom | 1 |
| Previous midwifery model | |
| Public hospital non-continuity model | 6 |
| Total | 11 |

## Data Collection

In depth interviews were conducted in an agreed quiet location, digitally recorded and transcribed verbatim. Participants were asked to describe their experiences of being WW during labour and birth and to reflect on any intersection between being WW in the context of the UMKO model. As is the tradition in phenomenology, questions asked reflected an intentional 'naïveté' (Giorgi, 1997) and stemmed from the main question "Can you describe

your experiences of being 'with woman' in the context of the model of maternity care you're working in?" One-to-one interviews lasted between 45 and 80 minutes and were conducted face-to-face by the primary researcher between December 2016 and October 2017. The interviewer, a midwife academic, was known to three of the participants as past professional acquaintances, however the potential for influence on participants' responses was considered minimal as the researcher had not worked in a clinical setting with any of these midwives. The interviewer was mindful of voice intonation and non-verbal gestures so as not to be directive or influence participant responses (Giorgi, 1997) . As is essential in descriptive phenomenological research, the process of bracketing was adopted. This involved suspending personal assumptions or prior conceptualisation of being WW and considering the phenomenon as described by the midwives (Giorgi, 1997, 2012). Strategies such as recording the author's assumptions about the phenomenon of being WW prior to commencing data collection, and maintenance of field notes and a research journal provided the opportunity to reduce any pre-existing thoughts and to facilitate reflection post –interview (Ortlipp, 2008). Regular meetings with the research team enhanced the bracketing process. Midwives were offered the opportunity to provide additional comments after the conclusion of the interview and two did this by email. Data saturation was observed after eight interviews, however a further three interviews were conducted which confirmed no new information to be discovered (Fusch & Ness, 2015).

### Analysis

Data analysis was guided by Giorgi's four stage phenomenological approach which was an iterative process and included (1) data immersion, (2) dividing data into concepts, (3) organisation and transformation of the data and (4) expressing the constituents of the phenomenon (Giorgi, 1997, 2012). Data immersion was facilitated by the primary researcher: conducting the interviews and later, reading and re-reading of transcripts while listening to the audio recordings. Next, individual 'meaning units' or conceptualisations were extracted. Classification and arrangement of qualitative data was facilitated by the use of data analysis software N-Vivo® (version 11). Step three included organisation and expression of the data, the commonality in midwives' description of their experiences revealed, and the essences of the phenomenon. In the final step, Giorgi (1997) asserts that

the researcher's disciplinary intuition is used to transform statements into concepts expressing the constituents of the study phenomenon. These concepts were supported by direct quotations from the interviews. For clarity and brevity, non-italicised words in square brackets [ ] have been inserted by the researcher to provide conversational context to descriptions and; where words were omitted this is indicated by an ellipsis (…).While presenting each theme and subtheme, supporting quotes from the midwives are offered in italics with a unique identification code (P1 to P11) to ensure confidentiality of the participants. The first author analysed all transcripts which were then analysed separately by at least one other member of the research team. Preliminary findings were discussed within the team until consensus was reached around themes and sub themes adding rigor to the data analysis. Any discrepancy was resolved by returning to the transcripts ensuring trustworthiness and credibility of the analysis (Giorgi, 1997, 2012).

## Findings

Two common themes, triad of relationships and; intersection of being WW in UMKO, with three and four respective subthemes arose from the data and are presented in Figure 1.

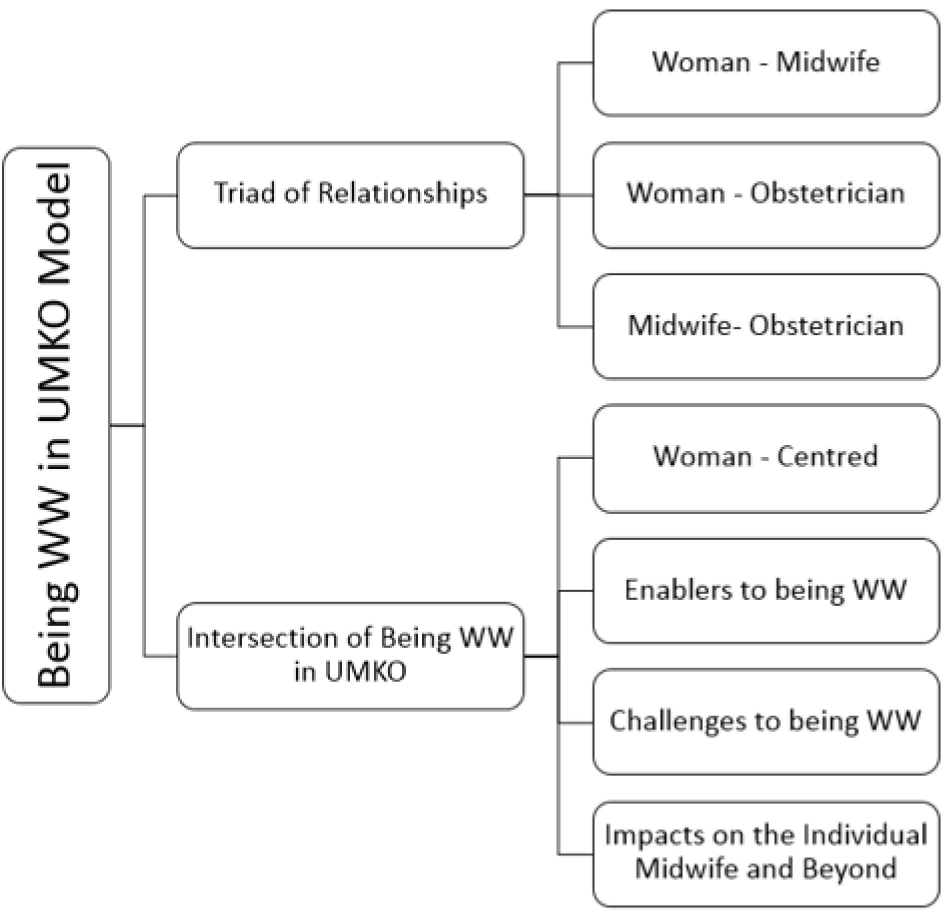


**Figure 1. Themes and Subthemes: Midwives being WW in the Unknown Midwife Known Obstetrician (UMKO) model**

## Triad of Relationships

Within the first theme of relationships, a unique triad between the woman, her obstetrician and the midwife was described as central to the practice of being WW (Figure 2). The context of the opportunities for relationship building within the triad were described as factors which enabled as well as challenged being WW. The complexities within this triad are reflected within three sub-themes.

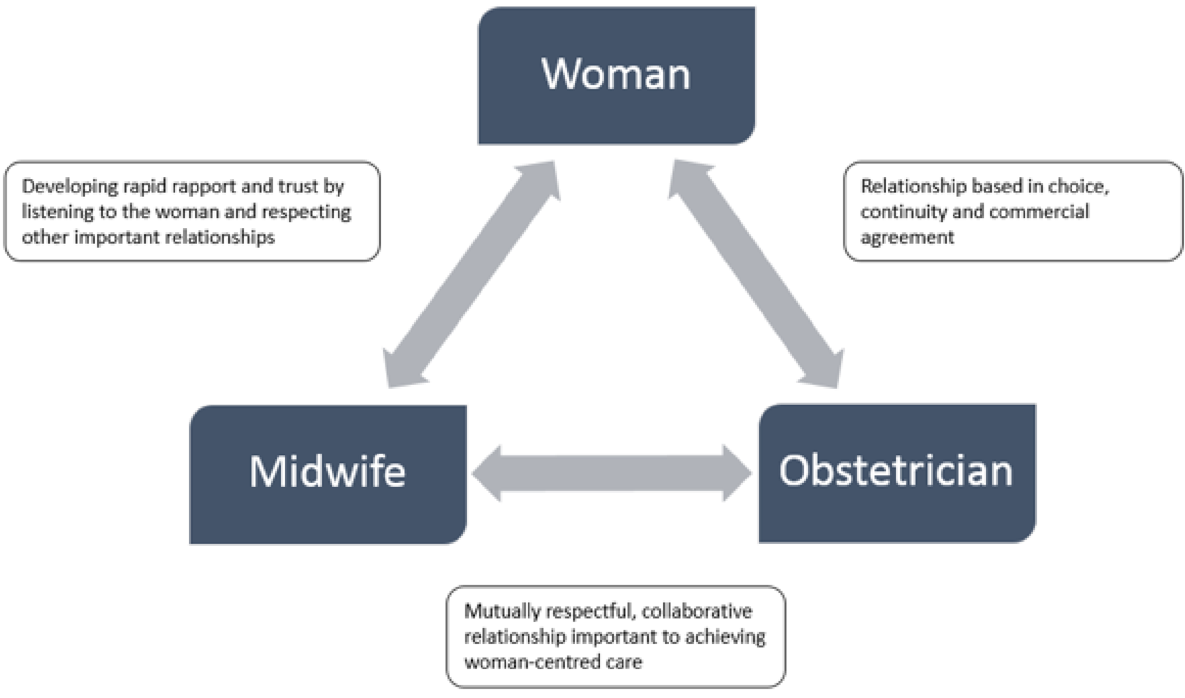


**Figure 2. Relationship Triad in Unknown Midwife Known Obstetrician - Private Obstetric Model, Bradfield 2018©**

### Relationship between woman and midwife

Midwives reported that their usual experience was to provide labour and birth care to women they had not previously met, and emphasised the importance of quickly developing rapport with the women as P3 commented *…midwives that work in this model have to be very rapid at developing good rapport.* The intimate setting of labour and birth both facilitated and necessitated the skill of developing a rapport with the woman quickly: *I think when you're meeting somebody for the first time in probably the most vulnerable state you get very good at quickly assessing and establish what it is that she needs to make that connection with her* (P10).

Midwives recounted examples that highlighted their strategies for achieving connection with the woman, which included the act of respectfully listening to what the woman wants, providing physical support, and being present in the room. These actions facilitated trust between the woman and the midwife. This trust, in turn, enabled the development of a professional relationship: *We get to know them* [the women] *really well in a very short time and the partner even, start with knowing a little bit about her and what she's looking for it's a real trusting kind of thing* (P8). Another participant shared her experiences: *… if you share a part of yourself you can actually establish a rapport a little bit quicker and you might find that they then have more confidence in you… you just need to work on what's important to that woman and pick up quickly how you're going to relate to her and which sort of a relationship you're going to have* (P7).

Another way midwives were able to be WW was to review a woman's birth plan if she had provided one. As P3 stated: the whole goal is to actually find out what the woman wants. What's her experiences, what she's looking for, what's her birth plan, her dreams and my goal is just to support her to get there…being non-judgemental and just providing her the best experience opportunity she wants, not what I want, what she wants.

It was suggested that the skill of efficiently building a professional relationship with a woman develops with experience as P3 noted: *you've got to do it quickly, some of the junior girls and the young graduates aren't as quick at forming relationships. They're not as skilled and over time us older ones we've learnt to use the right language so that we impart support.* A further strategy to developing the midwife – woman relationship, to facilitate being WW, was to be respectful and inclusive of other relationships that were important to the woman. Midwives recounted the importance of including the woman's partner in the labour and birth care and in doing so promoted being WW. As P2 stated: *…they* [partners] *are a part of the unit. It's really important that they're involved.* Midwives observed the impact of including the woman's partner and how this promoted trust between the midwives and women: *I think they* [women] *trust you a bit more if you are including them* [partners] (P10).

A final strategy to facilitate the relationship with the woman was to acknowledge and respect the relationship she has with her obstetrician. P9 recounted how the process of meeting a woman for the first time included: *explain how we keep in close contact with their obstetrician throughout the day and update them and call the obstetrician when it's time for them to come in.* Being WW and developing a trusting relationship with the woman was enhanced by respecting the woman's choices in others she had trusted relationships with and being inclusive as P10 explained: [being] *with a woman is also the fact that you need to … respect the person that they've chosen to look after them* [their obstetrician].

### Relationship between woman and obstetrician

Within this second sub-theme, midwives reported being mindful of the pre-existing relationship between the woman and the obstetrician and described their role in being WW in the context of this relationship. One participant shared that: …*this woman has chosen to be here, she wants this person* [obstetrician] *here, I don't feel as if the woman sees you as less as the obstetrician it's just that she's been there with him for 9 months, that relationship's there so they* [obstetrician] *just need to be there* (P10). Recognition also extended to the financial commitment women undertake in order to engage the services of the obstetrician: … [women are] *paying a lot of money for their* [obstetrician] *knowledge, their experience...* (P1).

The engagement between the obstetrician and the woman was acknowledged as offering continuity: *I appreciate that they've* [obstetrician] *got their continuity of care with the woman and the woman has chosen a particular model of care* (P2). Another insight was offered about the type of continuity that was provided and how this might differ between obstetric and midwifery care. P9 clarified that: *… appointments with the obstetricians are more measurement* [focussed] *whereas with us it's more emotional and developing that relationship with the woman, and partner.*

Midwives described further observations about the characteristics and quality of the woman-obstetrician relationship with examples from women about the apparent authority that obstetricians had. To illustrate, P11 suggested: …*the perception* [is] *that the obstetrician is God, and the midwives are just, you know we just empty the bins and mop up*

*the blood.* P6 expressed similar perceptions: *…patients often see the doctors as being so high up and midwives as not being anywhere near … they* [women] *bleat everything that the doctors say. The word of God just about.* An explanation was offered about what may contribute to women viewing obstetricians in this way: *The obstetrician is God and they* [women] *have got them that high up on that pedestal which… I guess is because of their rapport* (P1). This interpretation may acknowledge the power of the established relationship and trust developed between the obstetrician and woman within this continuity model.

Some midwives were willing to intersect with the obstetrician–woman relationship and encourage openness in an effort to provide agency to the woman if they felt her expectations were not being addressed: For example, P2 shared: *I always encourage a woman to talk, bring up if there's something that they want… it's really important that the conversation is had, whether I know that the doctors don't agree with it or not. I try to be really professional and respectful of the obstetrician but then it's really important that the woman has an opportunity if that's what she wants to do.*

The significance of the relationship between the woman and obstetrician was acknowledged by the midwives: *The relationship is between her and the obstetrician and my role is to support that relationship and be an adjunct to it not an interference* (P3). This relationship was seen to influence the midwives' ability to be WW as P5 suggested: [as the midwife] I limit my relationship a little bit sometimes because I know it's not me they [the women] are listening to.

### Relationship between midwife and obstetrician

In the final sub-theme, the professional relationship between the midwife and the obstetrician was highlighted as key within the triad. Specifically, the midwife and obstetrician may have forged a trusting working-alliance: *If you gain that rapport* [obstetrician - midwife] *and you've got that mutual respect then that team environment works so much nicer* (P4). Midwives also observed that a positive work relationship could result in less intervention in labour as the woman's expectations supported by the midwife were respected: *…we* [midwife and woman] *were able to present what we hoped would happen and he* [obstetrician] *was like 'ok I can work with that' and kind of left us alone then*

*for a lot longer* (P5). It was suggested that this is more likely to happen with obstetricians who seek collaborative input from midwives: *…the younger obstetricians coming through are happy to actually get your opinion and say what do you think is going on?* (P6)

Midwives reported that having relationships with obstetric colleagues that were mutually respectful and based on trust was built over time: *I think it's definitely experience and being in the one hospital for over 10 years, I've got respect and rapport with all the obstetricians* (P1) with a similar suggestion from another participant: *I think being older … and being in the game longer … I know them* [obstetricians] *really well so they have a bit more respect* (P7). This assertion was supported by comments about how junior midwives experience challenges until a respectful relationship can be developed: *…maybe a newer midwife coming out into this particular model that it would be harder* (P10). The relationship that midwives developed with obstetricians over time was a useful strategy to support being WW: *So having that good working relationship* [with the obstetrician] *then enables me to provide that woman with advocacy and that knowledge so that she can get what she wants*(P3). This was supported in an example by another midwife whose advocacy, through attempts at reducing intervention in labour, were heeded because of the working relationship: *Like if they* [obstetricians] *want to put a syntocinon drip up* [on]*… a multi*[para]*, I'll go 'you know, she's doing pretty well, can't we just rupture the membrane and wait for 6 hours?' I think because they know me and* [have] *confidence in me, most are pretty good* (P8).

Conversely, midwives also reflected on the impact of the power differential that is prominent in the UMKO model and how this can influence midwives being WW when there is disagreement between midwives and obstetricians: *They do tend to get a bit upset if things don't go their way…*[which] *makes you dislike the obstetrician and not trust them because they've undermined you and made you look stupid in front of this woman that you've … spent this time building up and empowering and making her feel confident that she can do this … the obstetrician just comes in, one fell swoop and the God has spoken and it's very frustrating* (P11). When care deviated from an obstetrician's preferences due to a woman's choice there were consequences as P5 reported: *I got screamed at for not having*

*given third stage* [injection of oxytocin]*. I can't give it 'cause that's abuse because I don't have* [the woman's] *consent to give it so you can shout at me as much as you want.*

The relationships developed within the UMKO model between the woman, midwife and obstetrician were inextricably linked. Relationship with the woman that is inclusive of her support people is an important part of being WW and acts as the foundation of practices that contribute to being WW, a hallmark of midwifery. In this model, a significant element of being WW requires inclusion of the woman's partner and her pre-existing relationship with the obstetrician.

## Intersection of being WW in UMKO

The second theme features midwives' rich descriptions about their experiences of being WW during labour and birth and the intersection between the phenomenon and the UMKO model of care. Midwives revealed manifestations of woman centred care and reflected on factors within the UMKO model that enabled or challenged being WW. Finally, midwives described how being WW impacted them both individually and more broadly, in their professional identity. The four sub-themes below represent the complexities of this theme.

### Woman-Centred Care

Providing woman-centred care was seen as important to being WW: *… it* [being WW] *means putting the woman in the centre of everything* (P10). One of the ways that midwives demonstrated being woman centred was to ensure that the care provided focussed on the woman's choices particularly during the time of labour and birth which can be a vulnerable time for women. Awareness and respect for the woman's choices meant that for midwives meeting the woman for the first time as she presented in labour or about to be induced, employed active listening to bracket their own thoughts which enabled being WW: *So I think it's building up a connection and hearing what it is they want… whatever your beliefs are about the different models of care, I feel when they're in the labour room is not the time* (P2). Midwives acknowledged that the professional philosophies of the obstetric–led model were not always congruent with midwifery philosophies but that supporting the woman's choice brought the focus on the woman: *reminding yourself, this woman has chosen this,*

*they wanted continuity of carer, they wanted that model, they wanted to be perhaps more directed and that's fine, that's their choice. So if you're constantly questioning that it feels like you're not being with them, you're not sitting with where they're at, you're imposing your philosophy onto that decision that they've made* (P5). By listening to women, midwives themselves enabled WW care in the face of challenges presented within the UMKO model by being flexible and putting aside their own opinions and thoughts.

To be WW and provide woman centred care meant that midwives were faced with challenges with obstetric colleagues and possible compromises: *…If it was going to cause some sort of conflict in the room or that air of you know, the elephant in the room, it's not worth it for her birth* (P7). Facing the need to compromise for the woman's benefit often came at cost to the midwives: *…because these women are contracted to these obstetricians you do take a step back, there's times when I could have walked out, the way I've been spoken to* [by an obstetrician] *but I'm not going to walk out on that woman 'cause it's not fair on the woman* (P4).

### Enablers to Being WW

Within this second sub-theme, midwives reflected that one of the ways working in the UMKO model facilitated being WW is through the practice where women are cared for one-on-one by midwives during labour as P6 reflected *…the fact that we're able to be one-on-one really does help … we're able to actually stay in there with the one woman on our own.* Having a ratio of one midwife to one woman in labour supported attributes of being WW such as intuitive and sensitive care: *… it does allow me to pick up a lot more on her needs and her anxieties and answer questions and educate, so I can see a positive in that and they* [the obstetricians] *sort of demand one on one care. They don't like us having more than one patient each* (P7).

When women formulated birth plans, this was seen as a tool that aided communication between the midwife and the woman and enhanced development of a trusting relationship *…her birth plan* [reveals] *her ideas, her fears* [and facilitates] *getting that trust so you've got that rapport and you can almost have a silent communication being on that journey with her… it's my pleasure to try and facilitate that for them* [women] (P11).

Midwives observed that being WW may be facilitated when midwives and obstetricians work collaboratively in a way that shows mutual trust and respect. Two quotes illustrate this: first, from P10*… because of that relationship with the obstetrician, they* [women] *like to know that we get along as well, it's important that respect and trust is there between the whole three of us in a way.* This was confirmed by P9 who described the outcomes when midwifery-driven initiatives were supported by obstetricians *…the doctors have taken that on board and allowed us to be with woman in that regards as well.*

With the goal of being woman – centred, midwives demonstrated their ability to be flexible and adaptive in the way they were WW according to the different circumstances *…because I know that's what the woman wants, that she wants him* [obstetrician] *there* [at the birth], *even though I might be stepping aside I'm just changing my role to do something else* (P10).

### Challenges to Being WW

Midwives offered insights into elements of the UMKO model that presented challenges to being WW during labour and birth. Just as collaborative and mutually respectful relationships between the midwives and obstetricians facilitated midwives being WW during labour and birth, so too, disrespect for and undermining of midwives by obstetricians to whom women were contracted, presented a challenge to being WW. Midwives were emotional when recounting experiences where they were subject to abuse and humiliation in the presence of the women they were caring for … *it's the intimidation of the obstetricians, there's just so many elements where the obstetricians speak down to the midwives in those settings and swear in front of the women, shout at us. We're not allowed to do anything for this particular obstetrician's women yet we're expected to just stand there and, well I try and build a relationship but then to not be able to do any clinical practice makes it quite a challenge* (P4)*.* Others spoke of the need to seek support from midwifery colleagues to engage with certain obstetricians: *I was quite scared, like I had to ask help from other senior midwives, 'this is what he wants me to do' and they're like 'don't do it, no.'* [I had to] *put my foot down with this doctor who loves to trample you* (P9)*.* The disrespectful behaviour of some obstetricians extended to a dominance over not just the way labour was

managed but also the actual birth itself: *We have to step back or else they actually physically bump us out the way, even though we're gloved up and everything* (P9).

Midwives repeated stories of being 'overridden' in their clinical judgement: *you know what you think should be happening and then someone comes in and overrides your judgement, the longer they've been in the profession of private obstetric practice they seem to think they're higher up and what they say goes and the midwife has no say over it* (P6). Midwives were reflective about the perceived impact this had on the woman and on themselves as professionals: *I find I step back and allow the obstetrician to just take over because I am so disempowered by … what he's just done to me and especially in front of the women. I don't agree with that kind of conduct in front of the women. It's not fair on the women and it's also not fair on me as a health professional* (P4). Midwives summarised the impact of these behaviours on being WW: *… definitely limits how much you can be 'with woman' and in what capacity you can be with woman* (P7).

A sense of 'injustice' of having to be silent was apparent where midwives were unable and unwilling to reciprocate the dominating behaviour of some obstetricians: *… You can't say anything negative about the doctor, in the end who are they [women] going to trust, someone who they've seen throughout their pregnancy or someone who they've just met? But it definitely plays an impact and you're made to feel kind of dumb and I don't know how some midwives just deal with it on a constant basis* (P9). Midwives were acutely aware of working in a system that appears to favour the obstetricians: [x hospital] *doesn't really support the midwife to stand up to the doctor, he brings the money in the door so anything he says is right* (P7).

Working in a model with high rates of intervention was described as a challenge to midwives being WW: *the more intervention you're doing, that takes time away from just being with the woman focussing on them* (P2). One frequently cited intervention during labour was epidural analgesia: *… when they* [women] *have got an epidural we do find that the midwives sort of step out of the room a little bit more … they almost think well the woman's not in pain now, I don't need to support her as much in that respect* (P6).

Midwives agreed that being WW during labour and birth involved providing education for women … make sure that she's informed about her choices and decisions … and she understands her choices and the pros and cons of those... (P3). At times, education was tailored and directed based on which obstetrician the woman was booked with as P5 recounts: I [put away] a lot of the education and advocacy because they [women] have already been told this is what's going to happen. They [women] are not making decisions because someone else is pretty much doing that for them. And they've chosen that model and they're happy so you don't want to be constantly questioning their choice of model and what they're doing….the extent to which you do it [education] is different and you frame things perhaps in different parameters. Another midwife shared: *there's definitely areas or topics of conversation that I would steer clear of if I was with a woman with a particular obstetrician…cause you'd just get a mouthful of abuse …* (P1). This participant illustrated the point with an occasion where she provided education regarding induction of labour to a multiparous woman who had been induced in all 3 previous pregnancies using amniotomy only. This method was again the woman's preference for induction of labour with this, her fourth pregnancy. The story continues: … *so she* [the woman] *asked the obstetrician just for the ARM and no synto and he looked at me and said 'you, out!' he believed that I told this woman just to have an ARM only, how dare I undermine his practice… I missed out on a birth because of that…* (P1).

There was a consensus amongst participants that advocacy is an important element of being WW *…to me it* [WW] *means you are her advocate* (P11). However, the UMKO model impacted the ways midwives could advocate, P7 explained the outcome of attempting to advocate: *You usually have a fight, I mean I've seen them* [doctors] *tear strips off some midwives.* Confrontation and conflict resulted when midwives advocated for women, particularly when women went on to choose care that was contrary to obstetricians' preferences. From P3: *I've learnt from past experiences 'cause I've been burnt, by the women… if I jump in and advocate, purely as the only voice between the woman and the obstetrician, that is not successful... Yeah burnt is my word for it because the women will happily then in front of the obstetrician just go, oh yeah ok, whatever you want. So I'm not going to stand up for the woman.* Another midwife described the process of 'putting away'

the midwifery processes of education and advocacy. As well as impacting midwifery practices, midwives shared how this influenced satisfaction with their work: *...that makes it really difficult and sometimes you just come home and you think to yourself well I couldn't advocate for that woman because I tried and then you get overridden unfortunately* (P6).

Participants described ways of navigating around these challenges when advocating for women and described encouraging women to advocate for themselves *So I've realised now that because the relationship is pre-existing before I'm in the picture that she needs to advocate for herself but she needs the knowledge and skills to do that. And the right words to use,* [to say what she] *wants and why she wants them* (P3). Another midwife explained: *I always say to the woman you know, you have that choice, this is your baby, this is your labour. If you don't want this intervention then just say no* (P7).

### Impacts on the Individual Midwife and Beyond

The final sub-theme is separated into three dimensions going beyond the individual midwife to the impact on midwifery practice and the profession of midwifery. Participants relay the way these areas intersect with the UMKO model and how each influenced being WW.

Midwives confirmed the importance of being WW: *… it's very important to be with women and empower them and get them engaged in their own decision making* (P4). Another acknowledged her motivation for being WW is implicit respect for women: *…because I respect women* (P8). There was a shared consensus that midwives themselves benefitted from being WW, many were emotional when describing the centrality of being WW as the work of midwifery: *I feel honoured* [being WW] *I still get teary every time, it's just fantastic, every experience is different* (P8). Another described *… It's fulfilling for me to be needed throughout that time* (P1). Midwives offered insight into the importance of continuing the practice of being WW despite challenges: *…certain models of care really impact the midwives' ability to do so* [be WW], *especially in the private system, we need to grow strong, resilient midwives that will trust their clinical findings and themselves and be confident so they can start challenging some of the obstetricians that are set in their ways …* (P4).

Midwives agreed that at times, being WW had a cost associated with it: *I think it's a much more intense relationship in labour and birth. It's one on one, all of your focus is on that person, you give yourself so much emotionally in that space* (P5). To appreciate the benefits and costs to being WW during labour and birth in the UMKO model, midwives shared how they reconciled their experiences: *I'm highly aware … of the pros and cons of working here and so I try to give the women a more positive experience here than just an ARM, oxytocin, induction of labour with an epidural with a vacuum at the end. I try to give them more … we are better than that. There's more to it than that* [but] *she can have that if she wants* (P3).For others, coping with the demands of working in a private obstetric model were relieved by rotating to other areas to relieve fatigue: *you've got your antenatal care, then you've got your postnatal care, you've got your parent education* (P8).

Participants reported that working in the UMKO model contributed to a reduction in midwifery scope of practice: *a lot of the midwives are losing skills because the obstetricians just come in and do the VEs* [vaginal examinations] (P1). Another supported this view: *I am very used to seeing midwives as being independent practitioners* [with their] *scope of practice, I don't feel like we are acknowledged as that at all in this model* (P5). The impact of a reduced scope of practice reflected on midwives' skills and their ability to be WW: *…if I can't use my clinical skills then I'm not performing to my complete scope* [of practice]*, there's only parts of midwifery that I'm using … whilst I'm with her and might be there psychologically and for emotional support, you can't enable her to make informed decisions … if you can't gain the clinical picture for yourself… it does impact in certain respects of being with them* [WW] *and providing safe, effective midwifery care. Models like this are just shutting midwives out of their care, we're deskilling all our midwives … autonomy is so impaired … How do you maintain your clinical skills if you're not allowed to do* [the skills]? *So for me it's disempowering the midwives as a* [professional] *cohort (P4).*

Further consideration of the impact of the UMKO model on midwifery practices included midwives' descriptions of lack of involvement in antenatal care influencing being WW during labour and birth: *…if we could be more involved antenatally with them it would be fantastic…I miss … just not having that build-up of antenatal care* (P8). For example, the first encounter with a midwife is often when an intrapartum intervention is required and

participants felt this did not facilitate being WW: … *the fact that* [you] *don't actually ever meet them 'til they present at the hospital either in labour or very rarely antenatally but you know or had to having something done, some sort of intervention* (P7). In contrast, one midwife provided insight on the experience of being WW during labour when she had met the woman during her antenatal care: *I have met* [the woman] *only once or twice. But that, that makes a difference… it just makes them feel less vulnerable, more comfortable* [during labour] (P6).

Midwives worked with these challenges and sought opportunities to get to know the woman: …*when women come in for CTGs or they're with us antenatally I will often spend a lot of time talking to them about what they're hoping for, what their aims are, and leave them in a position where they've got questions and things they want to clarify with their doctor so they're getting what they want rather than what they're being told* (P5). Others offered examples of how in meeting a woman for the first time, being a 'new' person provided opportunity to hear what the woman wanted: I am meeting them at the end of their journey … we're two perfect strangers you've just met me *…but I think that might even be a bonus because the woman can get stuck in just listening to what one person says … they've met me at the very end and she might see me as somebody* [who] *understands I actually want to do this but I haven't been able to say it* (P2).

It was suggested that hierarchical structures within the UMKO model impacted the professional identity of midwives: …*it makes you feel as though you're not really doing your job, and you sometimes come home and you think* [I've tried everything] *to get this woman what she wanted, I did everything I possibly could and then in the end it just changed because someone that is higher than me in terms of medical skills, hierarchy just said something and then that was it* (P6). The persistent overriding of midwifery care resulted in midwives questioning the boundaries of what separates the professions of nursing and midwifery : *… it just makes you not feel as though you're actually a midwife you are an obstetric nurse…. a lot of the time you're there to assist the obstetrician as opposed to care for the woman…I've even had a doctor before say to me, I don't know why they keep sending midwifery students here, this isn't a midwifery unit this is an obstetric unit* (P6).

Working as a midwife in a medical (UMKO) model challenged midwives' professional philosophy and required an acknowledgement of how women's choices intersected with their chosen model of care *… if I went in there thinking that induction of labour sucked and epidurals were wrong and that the woman should not have pain relief and they shouldn't have oxytocin infusions or monitoring and I came in with that preconceived judgement then that would be a disabler* [to being WW]… *it's a woman's choice to make her decisions* (P3).

Midwives' shared experiences highlighted the potential impact on workforce: *You're losing really competent midwives, they're just walking out the door. Your older midwives are so burnt out that they just can't say a positive thing about the place … You have to support them* [midwives] *because there's going to be a mass exodus from the midwifery workforce … there's so many older midwives that are going to leave* (P4).

At the same time, midwives also referred to the family-friendly and flexible rostering available in the private sector which influenced their decision to continue working in the UMKO model despite the challenges to their professional philosophy: *At the moment I'm doing what suits my lifestyle but I will not be staying there forever, I'll be out as soon as I have the opportunity* (P4). Many pointed to collegial relationships with other midwives and an ability to rotate to areas across the continuum of care as desirable features that could be a sustaining force: *It's really mercenary. They are the most flexible workplace and I need a flexible workplace… they are the most beautiful bunch of women to work with, supportive, incredible skill base, amazing midwives and I can choose to cherry pick the parts of the work where I feel I can fulfil my philosophy, and they* [managers] *allow me to do that* (P5).

## Discussion

This is the first study to explicitly explore midwives' intrapartum experiences of being WW within the private obstetric model. Findings reveal the influence of the phenomenon of being WW and provide insight into how this intersects with a medically dominant model that has been chosen by women. Similar to research conducted on other models (Davison et al., 2015), relationships are paramount to being WW, and insights about the uniqueness of this phenomenon in the context of the UMKO model are revealed. The intersection between

practices that manifest a commitment to the professional philosophy of being WW and the UMKO model reveal how the model can both enable and challenge midwives' being WW.

Midwives working in the UMKO model emphasised the importance of developing a rapid rapport and building respectful relationships with women in order to be WW. This is supported by findings from Norway where interviews of 10 midwives working in an obstetric led model showed that building relationships with the woman in labour was an important midwifery skill (Aune et al., 2013). Listening to what women wanted by encouraging dialogue and reviewing birth plans was an important strategy that midwives used to convey their respect and facilitate relationship. This is consistent with findings of research conducted with 271 women in Sweden, where their birth plans were found to facilitate development of a relationship with the midwife providing care in labour (Lundgren, Berg, & Lindmark, 2003). Midwives in our study emphasised that labour care that is inclusive of the woman's partner was an important part of being WW, also confirmed in a recent literature review (Bradfield, Duggan, et al., 2018). Many midwives around the world provide care to women they may not have previously met, however the uniqueness of the UMKO model is that the woman has a pre-existing relationship with a privately contracted obstetrician of the woman's choosing (Stevens, Thompson, Kruske, Watson, & Miller, 2014). The findings of our study confirm that the existence of an extra person of importance (obstetrician) in the professional relationship intersects with and influences midwives' being WW. This evidence offers fresh insight into the 'mechanics' of how professional relationships in the UMKO model are interdependent.

Whilst the focus of this study was not to gain women's perceptions on the relationship with their midwife or obstetrician, midwives were able to offer observations about the woman-obstetrician relationship given their lived experiences of working together in a close environment. Our findings revealed midwives' perceptions that women were receptive and keen for obstetrician involvement during labour and birth. Midwives' ability to 'welcome' the obstetrician into the birthing space was seen as a measure of respect for the woman and further facilitated the relationships between the woman and her obstetrician, in the triad. To our knowledge, there is no available evidence on the way women experience

engagement with their chosen private obstetrician and this concept, although beyond the scope of our research, warrants further investigation.

Our findings emphasised the importance of the relationship between the midwife and obstetrician in the UMKO model in WA. In the presence of mutually respectful and trusting relationships, midwives reported a nexus of care that was both collaborative and focussed on the woman. As there is no available evidence from Australian obstetricians on this perspective, further investigation could reveal the other dimension of this relationship triad in the context of the UMKO model. Insights from Morano et al., (2017) confirmed opinions from 72 obstetricians working in a public obstetric model in Italy, that collaborative relationships with midwives were valued and considered to be a source of reassurance and strength (Morano et al., 2017). Renowned midwifery leaders echoed the importance of collaborative working relationships across settings including the private obstetric model (Brodie & Leap, 2008). New knowledge provided in our findings confirms the resulting 'triad relationship' within the UMKO model and the interdependence of the relationship between the woman, midwife and obstetrician during labour and birth care.

Midwives considered the ways in which obstetric-led care conflicted with their understandings of a midwifery philosophy of care which values childbearing as a normal physiological event rather than a condition that requires medical intervention. Practices that increased medical intervention including early inductions, frequent epidurals and instrumental births were commonly reported; and adopted as a posture of 'doing to' rather than 'being with' woman. Higher rates of intervention in obstetric-led units are among the most frequently reported data when examining outcomes for women (Dahlen et al., 2012; Lutomski et al., 2014). Midwives shared how they felt conflicted with these medicalised practices and were challenged in how to support women who had made the choice and financial commitment to be in this model of care. One strategy shared by midwives when conflicted was to remain focussed on the woman and provide woman-centred care. Despite challenges to professional midwifery practice and philosophy (ACM, 2004), midwives described the act of 'keeping the peace' as being woman-centred. A similar concept was explored in a UK ethnographic study where over 800 antenatal consultations were observed and 383 interviews were conducted with pregnant women, obstetricians and midwives from

publicly funded obstetric led care units. Findings suggested that midwives who adopted the stance of 'going with the flow' did so to make their life easier, presumably by avoiding any potential conflict (Kirkham & Stapleton, 2004). Our findings offer insights into why and how midwives based in the UMKO model are able to continue to work in an environment that presented philosophical conflicts. The expectation to be 'with woman' despite the work environment meant that midwives were adaptive and flexible in their approaches to achieve this goal.

Australian midwives in our study reported the benefits of being able to provide one to one care to women during labour and birth and cited this as a factor that enabled them to be WW. Physical presence is a requirement for being WW (Aune et al., 2013; Leap & Hunter, 2016) and midwives have reported that this can be facilitated in the UMKO model. However, the practise of midwifery presence is not always valued by hospital administrators who perhaps are challenged to put a 'costing' on the intervention of presence (Aune et al., 2013). It is nevertheless an important element of being 'with woman' and has been written about by midwifery leaders across the world including the United Kingdom (UK) (Leap & Hunter, 2016), United States (US)(Hunter, 2009), Sweden (Hunter et al., 2008) and Norway (Aune et al., 2013).

The challenges to being WW in the UMKO model were described by midwives who communicated with emphasis and emotion, the experience of being overridden and disrespected by obstetric colleagues. This challenge contributed to midwives sharing feelings of being scared, intimidated and disempowered which could limit or reduce the opportunities of being WW. Jenkinson, Kruske and Kildea (2017) have suggested that when midwives feel disempowered by institutional settings, a protective stance may be to be 'with institution' rather than 'with woman' (Jenkinson et al., 2017). When midwives in our study described this scenario there was an apparent affect change to one of defensiveness or disappointment with a sense of regret and injustice, of a helpless situation with little hope for change. Private hospitals rely on the contractual relationship between the obstetrician and the woman for commercial viability. Challenging hierarchical structures could potentially offend doctors or contravene institutional policies which may present a risk to the business of maternity care or possibly, midwives' employment.

Midwives in this study were emphatic that a manifestation of being WW was to provide education to facilitate informed decision making by the woman. This stance was juxtaposed with descriptions about how midwives amend or omit certain elements of education based on which obstetrician the woman was booked to in accordance with the obstetrician's known practice preferences or dislikes. Whilst there is no further available evidence for the private obstetric model, this paradox is echoed in an Australian ethnographic study, set in the publicly funded obstetric-led setting, which observed care given to 16 women by midwives and obstetricians. Newnham (2017) revealed that midwives prepared women to be open to requirements of the 'system' rather than facilitating informed consent. It was offered that some midwives undertook this practice as a mechanism to shield women from feelings of guilt or regret if their birth did not go according to plan (Newnham et al., 2017). These conclusions support our findings and demonstrate the interpersonal and professional conflict that results when midwives have a philosophical commitment to facilitating informed decision making while simultaneously needing to ensure that institutional guidelines and policies as well as obstetrician preferences are met.

In our study, being WW required midwives to advocate for women, yet in the descriptions of midwives' experiences, there were accounts which illuminated the challenges of providing advocacy within the UMKO model. In instances where midwives advocated for women, where the woman wanted a different plan of care than the one prescribed by her obstetrician, midwives described the forceful responses they received characterised by words such as 'tear strips off', 'fight', 'burnt' and 'trampled'. Midwives relayed a change in approach to advocacy and acknowledged that the woman had formed a bond or relationship with their chosen obstetrician, and it was difficult or unwise to disrupt this bond. Insight from our findings revealed that midwives invested effort in encouraging women to advocate for themselves rather than bearing the consequences of 'coming between' the woman-obstetrician relationship. Midwives in our WA study reported that even when women were provided with knowledge and information to advocate for themselves, they capitulated and followed the obstetrician's original plan. The 'with woman' midwifery practices of education and advocacy have not previously been explored in the

context of the UMKO model, findings from this study offer support for further research in this area.

Midwives shared how working in the UMKO model affected their scope of practice and ability to be WW. They suggested that the lack of antenatal involvement with women in the UMKO model was a significant challenge to being WW during labour and birth. Within this model, midwives shared concerns that their scope of practice was diminishing, for example that they were not 'allowed' to perform vaginal examinations on the women contracted to certain obstetricians. Others relayed that their opportunity to be the primary accoucher during birth was limited and in many cases denied. Midwives were emphatic that limiting their clinical scope of practice impacted the philosophically- based practice of being WW. This provides interesting insight and confirms the interconnectedness of midwifery philosophy and practice – what impacts one, impacts the other. These findings were confirmed in a study by Davis and Homer (2016) who interviewed 12 midwives working concurrently in obstetric-led and midwifery–led models in Australia and the UK. These midwives confirmed that being 'with woman' was affected by the impacts on practice brought about by different institutional policies and models of practice (Davis & Homer, 2016).

Within our study, the impact upon the WW phenomenon so central to midwifery philosophy and practice was that midwives' professional identity was also impacted. References to performing the tasks of an 'obstetric nurse' or 'handmaiden' were made, indicating a shift in the very identification of the role of the midwife in the UMKO model (Kirkham & Stapleton, 2004). Midwives struggled to be WW and emphasised the challenges of working in a model where the dominating philosophy contrasted to their own, and added to the 'cost' of being WW. Despite the challenges, there was a sense of persisting hopefulness and optimism and midwives shared strategies that fostered resilience and sustainability. Midwives were attuned to their own needs and considered these. There was an acknowledgement that working in birth suite was particularly demanding and was the area most likely to produce inter-professional conflict. A strategy many midwives employed to reduce burn-out was to periodically rotate out of birth suite to postnatal care or the nursery, which was seen as an act of self-care and protection that promoted resilience. Relationships with midwifery

colleagues was another cited source of strength and encouragement, also supported by Hunter and Warren (2014) from research revealing UK midwives' experiences of workplace resilience (Hunter & Warren, 2014). Midwives in our study also cited the flexibility and family-friendly rostering practices unique to the UMKO model and acknowledged that for many, this was a sustaining feature. Whilst there is no known research about features that promote resilience and sustainability for midwives working in a private obstetric model, findings from recent research in Australia (Fenwick et al., 2018) and New Zealand (McAra-Couper et al., 2014) highlight that when midwives work in models that are consistent with their professional philosophy and provide midwifery continuity throughout the childbearing continuum, this acts as a sustaining force and enhances professional resilience. The new insights gathered in our research around factors that influence midwifery resilience in the UMKO model may serve as a basis for further investigation.

## Strengths and Limitations

A strength of this study includes the collection of data from midwives currently working in a private obstetric model in a variety of hospitals. This focus enabled midwives to reflect upon the intersection between being WW in the context of the private obstetric model which has not previously been explored. Midwives' self-selection into this study may suggest that they hold distinctive views of being WW compared to views of midwives working in other settings and findings must be considered within this context. While practices may differ in other Australian states and countries, the richness of the data presented allows the reader to determine any potential transferability of the findings to other comparable models of care or maternity settings.

## Conclusion

Findings from this study confirm the importance to WA midwives of relationships in being WW. The intersection between the phenomenon of being WW and the UMKO model has been revealed offering new insights into factors which facilitate and hinder this important practice. The impacts on the practices of being WW and practicing in accordance with professional philosophy are felt beyond individuals' practice and extend more broadly to

professional identity of the midwifery workforce as well as issues affecting resilience and sustainability. New knowledge derived from this research is important as it reveals professional, philosophical and practical challenges faced by midwives working in a model that represents a third of maternity services in Western Australia, and beyond.

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Abbreviations:

| | | | |
|---|---|---|---|
| WW | 'with woman' | UMKO | Unknown Midwife, Known Obstetrician |
| ARM | Artificial Rupture of Membranes | Synto | Syntocinon |
| CTG | Cardio Toco Graph | UK | United Kingdom |
| US | United States of America | NZ | New Zealand |
| WA | Western Australia | RM | Registered Midwife |
| RN | Registered Nurse | EN | Enrolled Nurse |

## Chapter Conclusion

This chapter has presented the final, published manuscript that addressed the study aim of exploring midwives' experiences of being 'with woman' in the context of the private obstetric model.

The next and final chapter offers a conclusion to this thesis by summarising the findings of the study in relation to the research aim and objectives, discussing implications and providing recommendations for clinical practice, education, professional leadership and policy as well as future research. A discussion on the strengths and limitations of the study is presented in addition to a final conclusion of the thesis.

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# Chapter 8 • Summary

## Chapter Introduction

This thesis includes the presentation of a phenomenological study which explored Western Australian midwives' perceptions and experiences of being 'with woman' in a variety of practice contexts. This final chapter offers a summary of key findings derived from the research with consideration to how the findings meets each of the study objectives. Implications and recommendations arising from this study for the midwifery profession, practise, research, policy, and health professional education will be presented. Finally, concluding remarks on the strengths and limitations of this study contribute to a summary statement.

The intention of this research was to build upon existing knowledge and reveal new insights about the phenomenon of being 'with woman' by exploring Western Australian midwives' perceptions and experiences of being with woman during labour and birth. The study objectives were to reveal the perceptions of the phenomenon of being 'with woman' from the perspective of midwives based in their experiences; and to understand what the necessary and invariant experiences of being 'with woman' were, in the context of a variety of maternity models of care. A significant outcome of this study is the revelation that midwives' perceptions of the phenomenon of being 'with woman' was described with similarity regardless of their years of experience, method of midwifery education and past experience of working in different models locally and internationally. Equally as important was the discovery that the concept and practices of being 'with woman' during the intrapartum period were experienced differently according to the model the midwife currently worked in. The methodology of descriptive phenomenology facilitated the adoption of an intentional openness to the phenomenon of being 'with woman' and was useful to provide descriptions of the essences of the phenomenon based in midwives' perceptions and experiences.

There are many advantages to the practice of concurrent publishing of findings of doctoral research over the presentation of a traditional thesis. Benefits include multiple stages of

peer review and feedback for each chapter article, early dissemination of important findings, and experience in the process of publication. However, owing to the journal formatting and word limitation requirements of publishers, only key findings were able to be selected and expanded upon in the discussion section of each chapter's published article. The findings of descriptive phenomenological research by their very nature are often extensive and expressive. Consideration was given to the value of including references in this summary chapter. In order to avoid repetition, improve readability and highlight the findings specific to this research, the utility of hyperlinking has been employed to direct the reader to where the finding was originally discussed in the context of the existing literature within each thesis chapter, in addition, a table summarising findings is presented in Appendix N. Rather than presenting a duplicate of the descriptive findings already covered in each chapter, this novel approach to providing a summary of the findings in this study is presented below. Presenting the findings in this way, with hyperlinks to the original thesis section, provides the opportunity for a clear display of the research findings in a manner that is easily accessible by the reader and offers enhanced transparency. This format also allows findings to be considered in the context of how they meet the research objectives which answers the question of "what did you find?" In addition, this approach allows for an integrated opportunity to appraise the implications and recommendations of the findings which address the important follow on questions of "so what; and now what?" This interactive approach will address the following:

- Findings –included as a hyperlink which, when selected in the electronic version of this thesis, links the reader to the original chapter section where the findings were discussed
- Objective– the finding is matched against the study objective(s) fulfilled
- New and/or supportive findings – indication is given to whether the findings are new or original; confirm findings of previous research or support current expert professional commentary
- Implications – the implications of the study findings are presented
- Recommendations – recommendations are provided to enhance the engagement and impact of the study findings and to identify areas for future research

## Assessing findings against the study aim and objectives

In order to facilitate discussion of the findings of this study and how each of the objectives have been addressed a reminder of the aim and objectives is offered. The aim of this study was to *explore Western Australian midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth.* This was addressed in the following two research objectives:

1. Explore Western Australian midwives' perceptions of the phenomenon of being 'with woman'
2. Explore the lived experiences of being 'with woman' during labour and birth from the perspective of Western Australian (WA) midwives working in a range of practice contexts.

A brief synopsis paragraph of the findings chapters is offered to remind the reader of the manuscripts presented in the four findings chapters. The manuscript in chapter 4 is currently under review and outlines 31 midwives' perceptions of being 'with woman' during the intrapartum period. The published manuscript in chapter 5 highlights and discusses the findings from interviews with ten midwives working in a 'known midwife' model with women during their labour and birth. Chapter 6 presents the findings and discussion of the experiences of ten midwives working with intrapartum women within a context of an unknown midwife model in the public hospital sector in WA. Finally, chapter 7 includes a published manuscript with the findings from interviews with 11 midwives working with intrapartum women in the private obstetric model who are not unknown to the women but the private obstetrician is known to the woman.

## Findings relevant to clinical practice

The findings derived from this study that have relevance to clinical practice are presented in the following paragraphs. Reference to the study objective fulfilled in addition to clarifying whether these findings are adding new knowledge, confirm other research findings or support current expert professional commentary are outlined. Finally, the implications and recommendations relevant to each finding are also provided.

- Findings revealed that being 'with woman' is not dependent on place of birth or model of care although different factors from each model can impact the midwives' experiences of being 'with woman'. This finding represents new knowledge and addresses both study objectives. The *implications* for this newly published evidence is that the construct of being 'with woman' is possible in all maternity models regardless of the option for continuity or not. The way that the phenomenon is experienced though, is different in each model. The *recommendation* within clinical practice for this evidence would suggest that midwifery students, graduates and professionals be encouraged to recognise that this phenomenon is relevant to midwifery and they must consider the intersection of their being 'with woman' in the context of the various models within which they provide midwifery care.
- Building a connection with the woman was found to be an essential feature of being 'with woman'; addressing both objectives 1 and 2. This finding supports professional commentary. The *implication* of this finding confirms that relationships are an essential construct and attribute of being 'with woman' within midwifery clinical practise across all models of care. *Recommendations* based upon this finding would suggest that midwifery students, graduates and midwives need to be aware of and prioritise strategies to build a connection that contributes to a relationship to facilitate being 'with woman' in their clinical practise.
- It was found that providing care to the woman that is inclusive of her support people is an important feature of being 'with woman'. This new evidence supports assertions made in professional commentary and fulfils both study objectives. The *implications* of having this evidence by specifically aiming to understand the phenomenon of being 'with woman' is useful to support midwifery practise that is centred on the woman and inclusive of those important to her. It is *recommended* that midwifery students, graduates and midwives should consider ways of providing care that respects the other relationships important to the woman and provides care in an inclusive manner.
- Findings revealed that midwives perceived that being 'with woman' in the context of the continuity models, enhanced their provision of safe care. As no study has previously sought to explicitly explore being 'with woman' in this way before, this

offers new evidence; addressing objective 2. The *implications* of this finding suggest that being 'with woman' in the context of continuity models may increase perceptions of, or practises that enhance clinical safety. *Recommendations* are for further research to explore midwives' perceptions of the features that contribute to the provision of clinical care considered safe in other models.

- The concept of being 'with woman' is practised across the continuum of care and features in antenatal, intrapartum and postpartum care. This new evidence which fulfils objective 2, supports the assertions made in professional commentary. Evidence that supports professional commentary is useful to reinforce midwifery practices asserted to demonstrate 'with woman' care across the continuum. Further research is *recommended* to confirm my findings and to explore the phenomenon of being 'with woman' in the antenatal and postnatal settings in different contexts.
- Although reported as the 'most ideal' model to enhance midwifery practices that demonstrate being 'with woman', another finding was revelation of the challenges that are experienced by midwives working in continuity models. Challenges included providing individualised, woman-centred care in environments and health systems that favour standardisation. This finding achieves study objective 2 and confirms assertions found in professional commentary as well as findings of previous research. The *implications* are an enhanced understanding of the challenges to being 'with woman' within continuity models which may be useful to devise strategies to mitigate the impacts of this. *Recommendations* are made for further research to explore factors that encourage midwives to be aware and consider the ways to mitigate the impact of challenges to being 'with woman' in any model.
- Findings reveal that midwives perceive woman-centred practices as the practical manifestation of being 'with woman'. This first ever published evidence of the perceptions and conceptualisation of how woman-centred care is a construct and manifestation of being 'with woman' fulfils study objective 1. The *implications* of having descriptors of the characteristics and practice attributes of being 'with woman', collectively described as being woman - centred, offers new knowledge; and is useful to understand how these two important constructs articulate in the professional identity, relationships and work of midwifery. *Recommendations* arise

from new knowledge obtained here which may be used to appraise current and future practice standards and supporting documents from midwifery professional bodies such as the International Confederation of Midwives, regulatory authorities and Colleges of Midwifery around the world.

- Forming rapid connections facilitates partnership with the woman and is important to being 'with woman 'in the unknown midwife model. Although the midwife-woman relationship has been explored previously, the way in which this specifically articulates into the phenomenon of being 'with woman' is new knowledge and fulfils study objective 2. The *implication* of this finding is the awareness that skills which enhance rapid connection with the woman are important for midwives, particularly when working in fragmented models. It is *recommended* that midwives should be supported to maintain or develop the necessary skills to establish a rapid connection in order to be with woman and provide care that is centred on the woman's agenda.
- Establishing mutually respectful and collaborative relationships between the woman, midwife and the woman's chosen private obstetrician was found to be important to facilitate midwives being 'with woman' in the private obstetric model. The *implications* of this finding offers first ever published evidence of the interconnection between the relationship 'triad' in this setting and being 'with woman' which fulfils study objective 2. *Recommendations* are made that midwifery and obstetric students, graduates and midwives be encouraged to consider their role, and ways in which mutually respectful collaborative relationships could be fostered in order to provide care that is focussed on the best outcomes for women.
- Findings reveal that midwives feel challenged in being 'with woman' by the frequent medical interventions experienced in the private obstetric model. This finding is supported in professional commentary but presents new evidence about midwives' experiences in the private obstetric model in the Australian context. *Implications* are that by presenting the first ever findings of midwives' experiences of being 'with woman' in the context of the private obstetric model we gain insight into how this important phenomenon intersects with this model of care which fulfils study objective 2. It is *recommended* that factors that inhibit midwives to be 'with woman' highlighted in this research should be considered by midwifery managers and leaders

in an effort to facilitate midwives to work in ways that are consistent with their professional philosophy.

- Midwives reported that they experienced a reduction in scope of practice within the private obstetric model which impacted being 'with woman'. The *implications* of this original finding of how midwives experience limitations in their scope of practice (comparative to other models) is that it enhances understanding about the impacts of this model on the phenomenon of being 'with woman' encompassing professional identity and practices which fulfils study objective 2. *Recommendations* from these findings would suggest that health service and professional leaders should consider ways in which the impacts of this model on midwives' scope of practice could be mitigated or reduced in order to preserve the unique and identifying philosophy and practises of midwifery within this context. Further research with a focus on factors that preserve midwifery scope of practice in the private obstetric model is recommended.

## Findings relevant to education

The findings derived from this study that have relevance to education are presented in the following paragraphs. Reference to the study objective fulfilled and clarification as to whether the findings are original, confirm other research or support expert professional commentary are presented. Finally the implications and recommendations of each of the findings are provided.

- Unique evidence presented in this research reveals the constructs of being 'with woman' and how it exhibits in the context of a range of Western Australian midwifery models of care. The *implications* of this finding which addresses both study objectives is that for the first time, we have a base of evidence to refer to when teaching midwifery students the features and role of being 'with woman' within the profession of midwifery. *Recommendations* are that leaders in midwifery curricula consider innovative ways to transfer an applied understanding of being 'with woman' which is so central to the profession. Further research is warranted on student midwives' perceptions and experiences of being 'with woman'; and on the

ways being 'with woman' could be embedded across midwifery curricula and clinical experiences.

- A noteworthy finding is that midwives expressed difficulty in describing the phenomenon of being 'with woman'. The *implications* of this important novel finding is that it demonstrates the need to provide language, essence and 'construct' to the phenomenon. Having a shared understanding of the phenomenon based in evidence such as that provided in this study enables communication of the same easier to midwifery students in order to develop graduates who can articulate the value, importance and role of professional philosophy in supporting midwifery practice. Midwives' assertions that being 'with woman' is something you 'do' indicates the applied practice nature of the phenomenon based in philosophy. The essences of the phenomenon along with descriptions of experiences in various contexts provided in this study fulfils both study objectives. *Recommendations* based upon these findings suggest that midwifery educators in all settings consider ways to use the findings in this study to enhance the literacy and description of professional philosophy, with a focus on drawing attention to the interconnectedness of philosophy and midwifery practice. Providing opportunities for clinical modelling of this nuanced but essential and identifying feature of midwifery practice which has also been found to be challenging to articulate is important.
- Midwives demonstrated adaptability in order to be 'with woman' in an individualised way. The *implication* of this finding which addresses both study objectives also provides new understanding that adaptability is required in order to be 'with woman' is useful to include in the skills complements of midwifery students, graduates and midwives. *Recommendation* for the inclusion of teaching and learning of adaptability skills such as scenario based approaches in midwifery curricula and in graduate program training should be considered. Experienced midwives who identify that they struggle with being adaptive should be supported to increase these skills to enhance being 'with woman'.
- Being 'with woman' in the context of continuity models enhances midwives' reflexivity and desire for continuous professional development. The *implication* of this new finding addressing objective 2 is an understanding of how the relationship

developed in the 'with woman' process provides a space that increases reflexivity and drives the desire for professional development in midwives. The *recommendation* from this finding in light of increasing availability of continuity models would suggest that further research be undertaken to explore factors that motivate midwives to undertake reflective practice and further professional development. In addition, ongoing provision of professional development that focuses on enhancing midwives' skills for reflection and reflexivity especially as it relates to being 'with woman' in their own clinical context is warranted.

## Findings relevant to professional leadership and policy

The findings derived from this study that have relevance to professional leadership and policy are presented in the following paragraphs. Reference to the study objective fulfilled and clarification as to whether the findings are original, confirm other research or support expert professional commentary are presented. Finally, the implications and recommendations of each of the findings are provided.

- The first finding here is that being 'with woman' is a key component in identifying midwifery practise. The *implications* of this finding, which supports professional commentary but is presented for the first time here in evidence, is provision of descriptions of midwives' perceptions of what being 'with woman' means, how it manifests in clinical contexts and is conceptualised by midwives. Understanding how midwives perceive as well as practice the phenomenon is valuable as it offers a glimpse of what is 'ideal' or desired in being 'with woman' and then how working in various models intersects with this construct and conceptualisation of being 'with woman'. This finding addresses both study objectives. The *recommendation* is that the new evidence provided in this research be considered by midwifery leaders and professional bodies for how it can support the declarations in the professional philosophy statements of midwifery professional bodies worldwide including the numerous Colleges of Midwifery and Midwifery Associations.
- Continuity models facilitate 'with woman' practices and enhance culturally sensitive care. This finding fulfils study objective 2 and confirms findings of recent Australian-

based research as well as offering unique and broader perspectives on culturally sensitive care. The *implication* of this finding is that by providing access to continuity models which facilitate midwives to be 'with woman', services may offer care that is more culturally sensitive. The *recommendation* from this finding would be that service providers consider ways in which they can develop additional and sustain existing continuity models.

- Being 'with woman' in the context of continuity models is rewarding and sustaining for midwives. The *implications* of this finding, which confirms results of other recent research is that it shows emerging themes of the role of the model of maternity care (specifically continuity of care ) in enhancing midwives' wellbeing and choice to stay in the profession.  This finding addresses study objective 2. *Recommendations* are made for a review of where traditional recruitment and retention strategies have focussed principally on remuneration and industrial relations conditions. Further research is warranted into the role of maternity models in aligning with professional philosophy enabling midwives to be 'with woman' in attracting and retaining a midwifery workforce.
- Increased medical interventions, workloads and fragmented care characteristics of the unknown midwife model impact the practice of being 'with woman'. This finding as it specifically relates to the phenomenon of being 'with woman' is new,  although in principal confirms other research and expert professional commentary which has addressed the impacts on interventions on women's experiences of care. The finding fulfils study objective 2. *Implications* of this finding is that it brings an awareness of the factors that challenge midwives being 'with woman'. An awareness of the factors which challenge being 'with woman' enhances the ability to mitigate impacts. *Recommendations* for service leaders would be to urge consideration for the systems-based impacts on midwives being 'with woman' and explore ways to reduce and manage these.
- In the private obstetric model, midwives who sought to facilitate 'with woman' practices such as advocacy and informed decision making, where the result was the woman choosing a plan of care not preferred by the contracted obstetrician, experienced exclusion from clinical care and verbal abuse. The *implications* of the

new evidence presented reveals the extent of the impact of the private obstetric model on midwives' being 'with woman' but also their inter-professional relationships. These findings address study objective 2. The *recommendation* is made for further research in similar models around Australia to determine if this phenomenon exists beyond the WA context. Midwifery and obstetric managers have an imperative to encourage reporting of unprofessional behaviour and providing supportive workplaces.

- With woman practices such as advocacy and education were at times amended by midwives working in the private obstetric model to suit institutional requirements and individual obstetrician preferences. This finding addresses study objective 2. The *implications* of this new evidence reveals the pressures experienced by midwives in this model to conform to system and obstetrician preferences in ways that could compromise professional practice standards and philosophy. *Recommendations* are that midwives be supported to be 'with woman' and demonstrate this through the woman-centred (and professional standards) practices of advocacy and facilitation of informed decision- making based in evidence without fear of reprisal.
- To reduce burn-out attributed to providing care that transgressed 'with woman' philosophy – midwives in the private obstetric model took advantage of the family-friendly rostering and rotation to areas other than birth suite as required. This novel finding addresses study objective 2. The *implications* of this first ever glimpse at the self-preservation strategies employed by midwives in this model to enhance career longevity, reveals some of the factors that enhanced resilience. It is *recommended* that further research is undertaken to explore factors that impact workforce sustainability in this model with consideration to aspects that influence sustainability in other settings such as woman-centred continuity models.

## Findings relevant to research

Many of the findings derived from this study that have relevance to research are interwoven in the previously summarised findings as part of recommendations. Additional recommendations for research arising from this study are also outlined below. Recommendations for further research do not directly fulfil the objectives of this study but

rather, identify from the findings of this research, areas requiring further evidence. The anticipated outcome or implications of undertaking further research are provided.

- Further research is recommended to explore the features of being 'with woman' across the continuum including antenatal and postnatal care which would provide an understanding of the features of being 'with woman' across the childbearing continuum.
- An exploration of how being 'with woman' is experienced from the perspective of the woman's partner or significant others could be considered. This would offer respect for the role of the support person in seeking to understand their perspectives which further enhances midwives' ability to be 'with woman' in a way that is inclusive of partners or support people.
- Further research should be conducted on women's experiences of care in different models in a way that either seeks to describe or compare the experiences which would provide unique insight into individuals' expectations and actual experiences of various models of care.
- An area for future research identified in this study is to more broadly explore midwives' experiences of working in different models rather than experiences specific to being 'with woman' covered in this study. This would add to the current knowledge that considers experiences in one context by offering descriptions of different contexts from the same midwife.
- Further research is warranted on the impact of, and women's reasons for, declining to engage in professional relationships or partnerships. A complex and nuanced phenomenon, having better understanding of this would assist midwives to develop skills sensitive to women who decline the offer of partnership.
- Further study is indicated to explore the best way to teach midwifery students the phenomenon of being 'with woman'. As evidenced in this study, being 'with woman' is fundamental to the profession of midwifery. With enhanced understanding of the phenomenon provided in this research, discovering how this important construct might be best communicated and modelled would be useful.

- Capitalising on the new knowledge derived from this study, further research is warranted on women's perceptions and experiences of their relationship with a chosen, contracted private obstetrician which would address a current gap in research in this area.
- Expanding on the discoveries made here, further research should be conducted on private obstetricians' perceptions and experiences of their continuity relationship with women contracted to them which would also address a current gap in research in this area.

## Strengths and Limitations

Within any study, there are features which may contribute to the strength or limitations of the research. The strengths and limitations relating to this particular study are covered here.

### Strengths

The strengths of this research are plentiful but are derived principally from the range and variation of the experience of being 'with woman' described in this study which allows a comprehensive presentation of the necessary and invariant ways that midwives i) perceive; and ii) experience the phenomenon of being with woman in the current model of care they are working in. In-depth descriptions are facilitated through the guiding philosophy of descriptive phenomenological research. In addition to this, the methods offered by Giorgi have resulted in a broad understanding of how midwives themselves conceptualise the phenomenon of being 'with woman'. Midwives were able to describe the essences of their understanding of what it means to be 'with woman' by revealing the characteristics inherent to the practice of being 'with woman' based in their experiences; and by describing how the phenomenon articulates with professional identity.

This is the first study of its kind using in-depth interviews to gain an understanding of the phenomenon of being 'with woman' as it is experienced by midwives themselves. This unique perspective offers much needed evidence to support and extend the current knowledge around the phenomenon, currently based on expert commentary and limited

studies that have made ‘serendipitous’ discoveries that are principally based on women’s experiences of midwifery care.

Concurrent publication of findings in high impact, peer reviewed journals adds strength, as the study is reviewed multiple times by co-authors within the research supervision team as well as independent expert peers. The process of reviewing and adopting feedback is useful and adds to the overall rigor of this research.

### Limitations

Whilst obvious bias and limitations were mitigated in the initial research planning phase, there were a few factors that could not be changed that may present a limitation to the study.

Midwives self-selected into this study according to the inclusion criteria for recruiting which may suggest that they hold distinctive views about being ‘with woman’ compared to counterparts not interviewed. However, the rich descriptions of the phenomenon of being ‘with woman’ facilitated by the methodology of phenomenology; in addition to the comprehensive demographic data provided, facilitates decision making by the reader around  the transferability of the findings of this study to other maternity settings.

The researcher’s work as a midwife and assumptions regarding the phenomenon could be considered a limitation or factor for bias. However, the process for addressing and managing this is clearly described in the methodology chapter which accounts for the process of phenomenological reduction and bracketing, as well as other numerous other strategies that enhance rigor such as credibility, dependability, confirmability and transferability.

## Chapter Conclusion

This final thesis chapter has summarised the findings of this doctoral study and demonstrated how the findings have achieved the aim and objectives of this research which was to explore Western Australian midwives’ perceptions and experiences of being ‘with woman’ during labour and birth. A novel approach that provides clarity and transparency

has been used to display the implications and recommendations derived from this research with the inclusion of a hyperlink to where these were originally discussed in the thesis. The factors that both contribute strength and offer limitations have been discussed. In conclusion, the research aim and objectives were achieved resulting in the generation of new knowledge and much needed evidence about the phenomenon of being 'with woman' which is central to the profession of midwifery as it is practised around the world .

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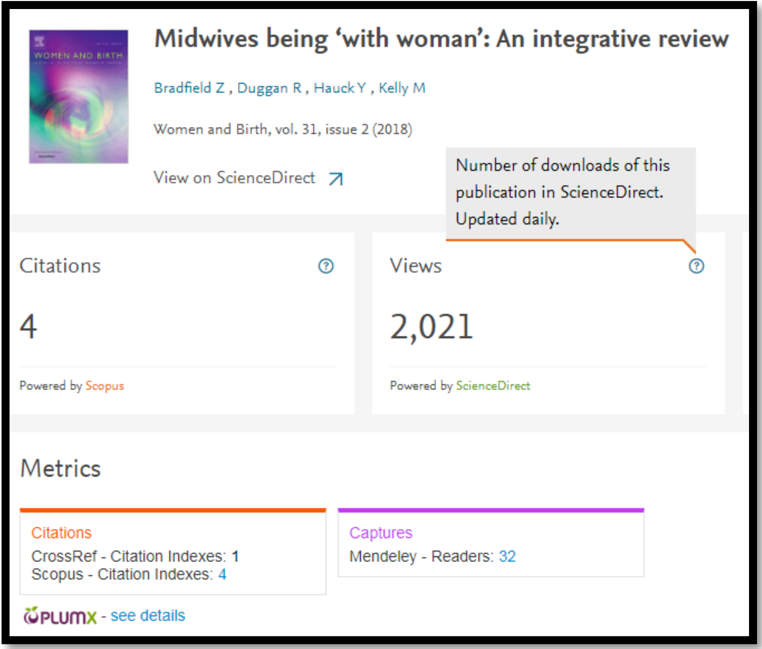
## Appendix A

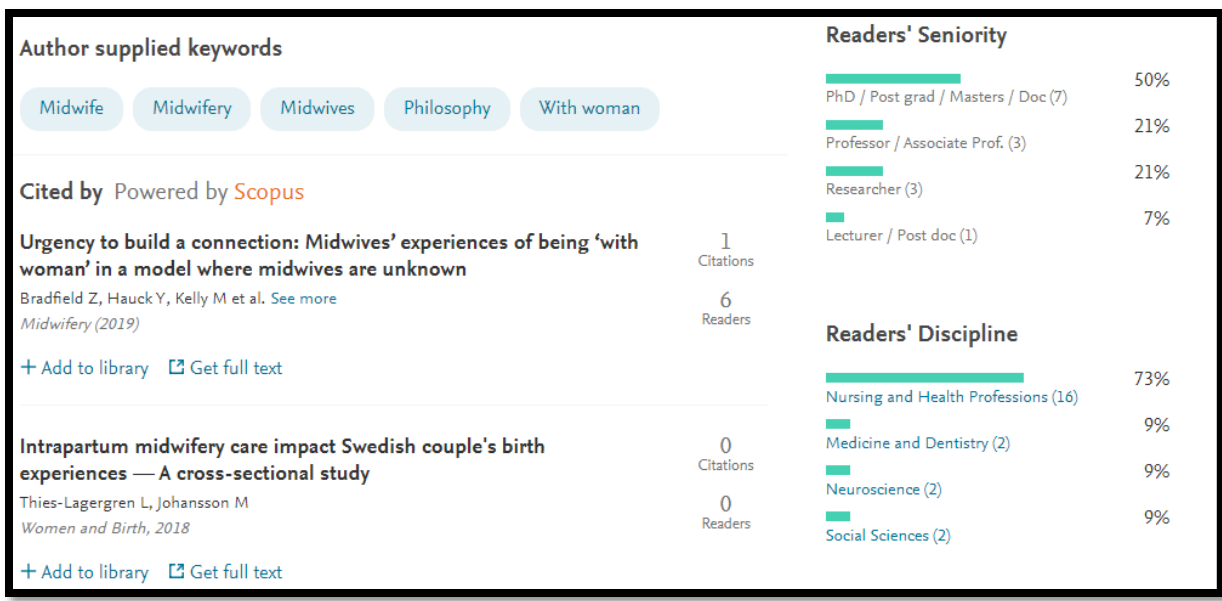
Copyright clearance confirmation for: Midwives being 'with woman': An integrative review

# Appendix B

Research Engagement Evidence: Midwives being 'with woman': An integrative review




Mendeley statistics showing 2,021 downloads since publication in April 2018




Mendeley statistics showing articles citing this research as well as breakdown of readers by profession and academic level

# Appendix C

Research Activity and Outcomes Timeline

The following table indicates:

- The main activities of the doctoral research process indicated by light shading □.
- Outcomes and major milestones are indicated in the darker colour □.

| | M 16 | A 16 | M 16 | J 16 | J 16 | A 16 | S 16 | O 16 | N 16 | D 16 | J 17 | F 17 | M 17 | A 17 | M 17 | J 17 | J 17 | A 17 | S 17 | O 17 | N 17 | D 17 | J 18 | F 18 | M 18 | A 18 | M 18 | J 18 | J 18 | A 18 | S 18 | O 18 | N 18 | D 18 | J 19 | F 19 | M 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Enrol in PhD. Merit selected for Scholarship | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Commence literature search | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Doctoral induction ethics training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Methodology research | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oral Presentation to School Research Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Application for Candidacy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conduct Integrative Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Candidacy Approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethics Approval | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recruitment and Interviews | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conference presentations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Data analysis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare findings manuscript KM Model | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare findings manuscript UMKO Model | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conference Presentation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conference Presentation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare findings manuscript UM Model | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare findings manuscript Midwives' Perceptions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare Thesis drafts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oral Presentation to School Research Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submit Thesis for Examination | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

## Appendix D

Transcription Confidentiality Agreement

**Confidentiality Agreement for Transcription**

**Faculty of Health Sciences, Graduate Research School, Curtin University**

**Title of the Research Project**

Western Australian Midwives' Perceptions and Experiences of the Phenomenon of Being 'With Woman' During Labour and Birth

I, Andrea Tongue, Transcriptionist, agree to maintain full confidentiality with regard to any and all audio files and documentation received in relation to this research project being undertaken by Zoe Bradfield.

I agree to the following:

1. To protect the identification of any individual that may be unintentionally/accidentally revealed during the transcription of digitally recorded audio interviews, or in any associated documents.

2. To not make copies of any of the transcribed/translated interview texts, unless specifically requested to do so by Zoe Bradfield

3. To store all study related materials in a safe, secure location as long as they are in my possession.

4. To return all study-related documents/materials to Zoe Bradfield when the assigned work is completed.

5. To delete/ dispose of all hard copies/soft copies of study-related documents.

I am aware that I can be held liable for any breach of this confidentiality agreement.

Transcriptionist's Name (printed) ...Andrea Tongue

Transcriptionist's Signature ......A. Tongue...... Date :.........20/02/20107

# Appendix E

Ethics Approval

Office of Research and Development

GPO Box U1987
Perth Western Australia 6845

**Telephone** +61 8 9266 7863
**Facsimile** +61 8 9266 3793
**Web** research.curtin.edu.au

10-Nov-2016

Name: Ravani Duggan
Department/School: School of Nursing, Midwifery and Paramedicine
Email: R.Duggan@curtin.edu.au

Dear Ravani Duggan

**RE: Ethics approval**
**Approval number: HRE2016-0450**

Thank you for submitting your application to the Human Research Ethics Office for the project **Western Australian midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth** .

Your application was reviewed through the Curtin University low risk ethics review process.

The review outcome is: **Approved**.

Your proposal meets the requirements described in National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **10-Nov-2016** to **09-Nov-2017**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

| Name | Role |
| --- | --- |
| Duggan, Ravani | |
| Bradfield, Zoe | Student |
| Hauck, Yvonne | Supervisor |
| Kelly, Michelle | Supervisor |

**Standard conditions of approval**

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
    - proposed changes to the approved proposal or conduct of the study

- unanticipated problems that might affect continued ethical acceptability of the project
- major deviations from the approved proposal and/or regulatory guidelines
- serious adverse events

3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project
5. Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised
6. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project
7. Changes to personnel working on this project must be reported to the Human Research Ethics Office
8. Data and primary materials must be retained and stored in accordance with the Western Australian University Sector Disposal Authority (WAUSDA) and the Curtin University Research Data and Primary Materials policy
9. Where practicable, results of the research should be made available to the research participants in a timely and clear manner
10. Unless prohibited by contractual obligations, results of the research should be disseminated in a manner that will allow public scrutiny; the Human Research Ethics Office must be informed of any constraints on publication
11. Ethics approval is dependent upon ongoing compliance of the research with the Australian Code for the Responsible Conduct of Research, the National Statement on Ethical Conduct in Human Research, applicable legal requirements, and with Curtin University policies, procedures and governance requirements
12. The Human Research Ethics Office may conduct audits on a portion of approved projects.

**Special Conditions of Approval**
None.

**This letter constitutes ethical approval only.** This project may not proceed until you have met all of the Curtin University research governance requirements.

Should you have any queries regarding consideration of your project, please contact the Ethics Support Officer for your faculty or the Ethics Office at hrec@curtin.edu.au or on 9266 2784.

Yours sincerely

Dr Catherine Gangell
Manager, Research Integrity

# Appendix F

## Research Information Form

### Information Sheet

**Study Title: Western Australian midwives' perceptions and experiences of the phenomenon of being 'with woman' during labour and birth.**

**Research Team:** Zoe Bradfield, Assoc Prof Ravani Duggan, Prof Yvonne Hauck and Assoc Prof Michelle Kelly.

Dear Midwifery Colleague,

You are invited to participate in research that is being conducted as part of my doctoral studies. The aim of this study is to explore and describe Western Australian midwives' experiences of being 'with woman' when providing care during labour and birth.

The concept of being 'with woman' in labour and birth is firmly embedded within midwifery professional philosophy, practise codes and standards. To date, there has been little research to understand how this translates into clinical practise. By participating in this research, a better understanding of midwives' being 'with woman' will be gained through descriptions of the practice.

You are requested to participate in an interview. It is anticipated that interviews may last approximately an hour. The researcher will meet at a time and place that is suitable to you. Midwives in rural and remote locations are encouraged to participate and Skype™/ telephone interviews may be arranged. All data will be de-identified and will not be able to be linked to you or your place of work in any way. Digitally recorded interviews will be transcribed, both will be stored on a special Curtin University Research Drive that is encrypted and password protected. Any hard copies (paper/ USBs) will be stored in a locked drawer in the researcher's locked office for 7 years after which they will be destroyed in accordance with the National Statement on Ethical Conduct in Human Research (2007). Confidentiality is assured and protected through the means listed above. Only the researcher and the listed supervisors will have access to the information.

If you agree to participate in this research, you will be requested to provide written consent. While there is no direct benefit to you for participating in this study, you will be contributing to midwifery knowledge around the experience of being with woman that will be shared with the midwifery community through publications. You will be given a certificate of participation in research which may be added to your professional portfolio. You may withdraw from the study at any time, if your interview is complete, you may indicate whether you wish to withdraw the information. Whilst discomfort is not anticipated, should an issue of concern arise as a result of participating in this research, the Employee Assistance Program (EAP) will be available to provide free and confidential counselling or debriefing if required.

If you are interested in contributing to this research or have any further questions please contact the researcher on the details provided below.

Zoe Bradfield

PhD student, School Nursing, Midwifery and Paramedicine, Curtin University

Phone 0439930206, Zoe.bradfield@curtin.edu.au

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC 2016-0450). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

# Appendix G

Research Consent Form

## Consent Form

| HREC Project Number | HRE 2016 - 0450 |
|---|---|
| Project Title | Western Australian Midwives' understanding and experiences of being 'with woman' during labour and birth. |
| Research Team | • **Zoe Bradfield**, PhD student, School of Nursing, Midwifery and Paramedicine<br>• **Assoc Prof Ravani Duggan**, Deputy Head of School of Nursing, Midwifery and Paramedicine<br>• **Professor Yvonne Hauck**, Professor of Midwifery School of Nursing, Midwifery and Paramedicine<br>• **Assoc Prof Michelle Kelly,** Director Community of Practice, School of Nursing, Midwifery and Paramedicine |
| Version Number | |
| Version Date | |

- I have read the information statement version listed above and I understand its contents.
- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that in the event of this work being published, my participation will not in any way be identifiable.
- I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of this information Statement and Consent Form.

| Participant Name | |
|---|---|
| Participant Signature | |
| Date | |

**Declaration by researcher:** I have supplied an Information Letter and Consent Form to the participant who has signed above and believe that they understand the purpose, extent and possible risks of their involvement in this project.

| Researcher Name | |
|---|---|
| Researcher Signature | |
| Date | |

## Abstract H

Copyright clearance for: "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model

RightsLink®

**Title:** "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model

**Author:** Zoe Bradfield, Yvonne Hauck, Michelle Kelly et al

**Publication:** BMC Pregnancy and Childbirth

**Publisher:** Springer Nature

**Date:** Jan 1, 2019

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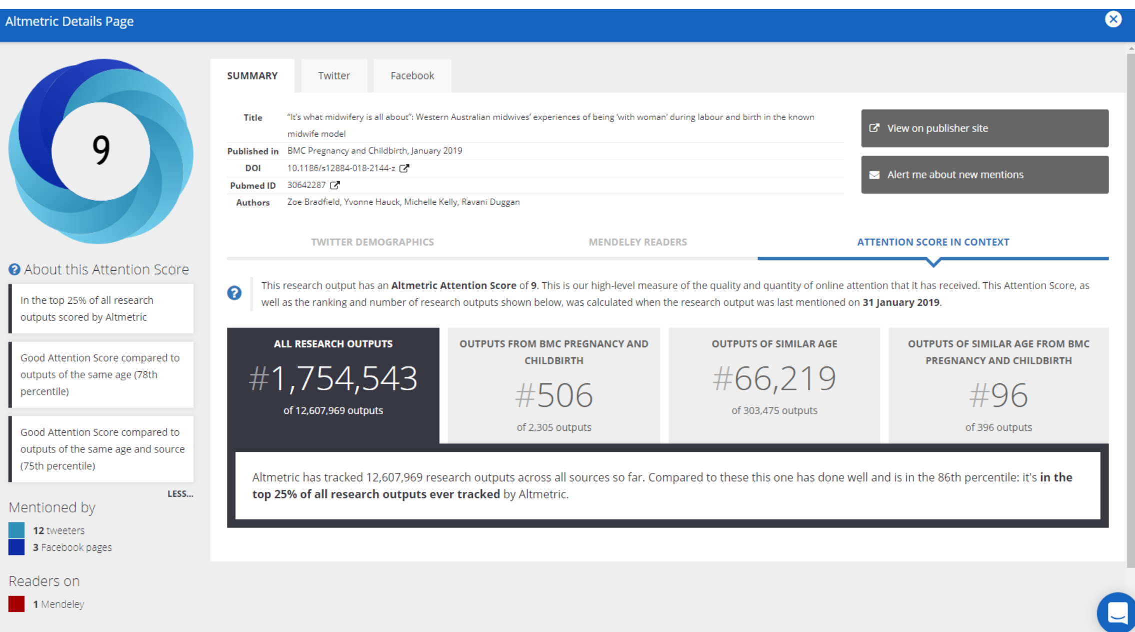
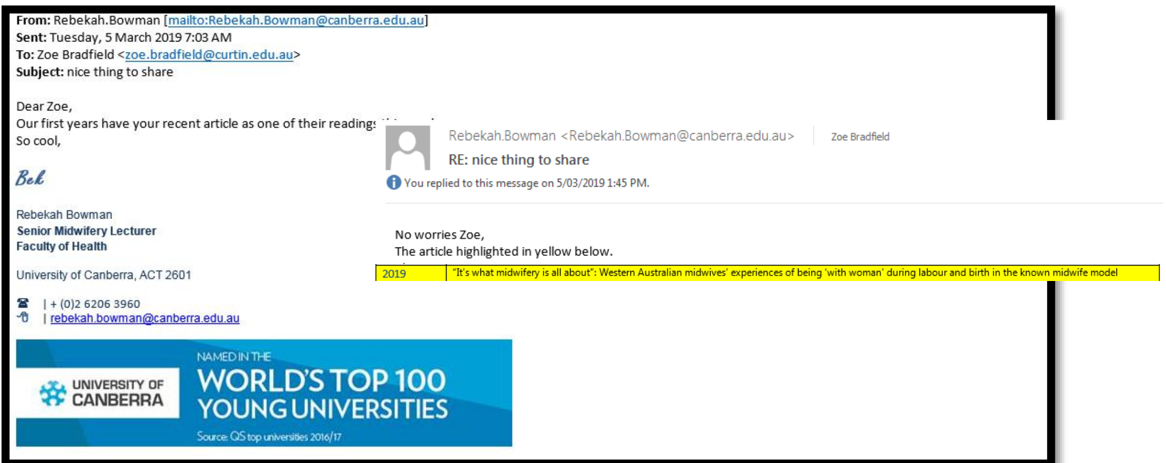
# Appendix I

Research Engagement Evidence: “It’s what midwifery is all about”: Western Australian midwives’ experiences of being ‘with woman’ during labour and birth in the known midwife model




Altmetric details showing the high ranking and attention score of this article



**From:** Rebekah.Bowman [mailto:Rebekah.Bowman@canberra.edu.au]
**Sent:** Tuesday, 5 March 2019 7:03 AM
**To:** Zoe Bradfield <zoe.bradfield@curtin.edu.au>
**Subject:** nice thing to share

Dear Zoe,
Our first years have your recent article as one of their reading:
So cool,

Bek

Rebekah Bowman
**Senior Midwifery Lecturer**
**Faculty of Health**

University of Canberra, ACT 2601

| + (0)2 6206 3960
| rebekah.bowman@canberra.edu.au

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Rebekah.Bowman <Rebekah.Bowman@canberra.edu.au> Zoe Bradfield
RE: nice thing to share
You replied to this message on 5/03/2019 1:45 PM.

No worries Zoe,
The article highlighted in yellow below.

| 2019 | “It’s what midwifery is all about”: Western Australian midwives’ experiences of being ‘with woman’ during labour and birth in the known midwife model |
|---|---|

Email correspondence from University of Canberra midwifery lecturer confirming article as prescribed reading for midwifery students (shared with permission).

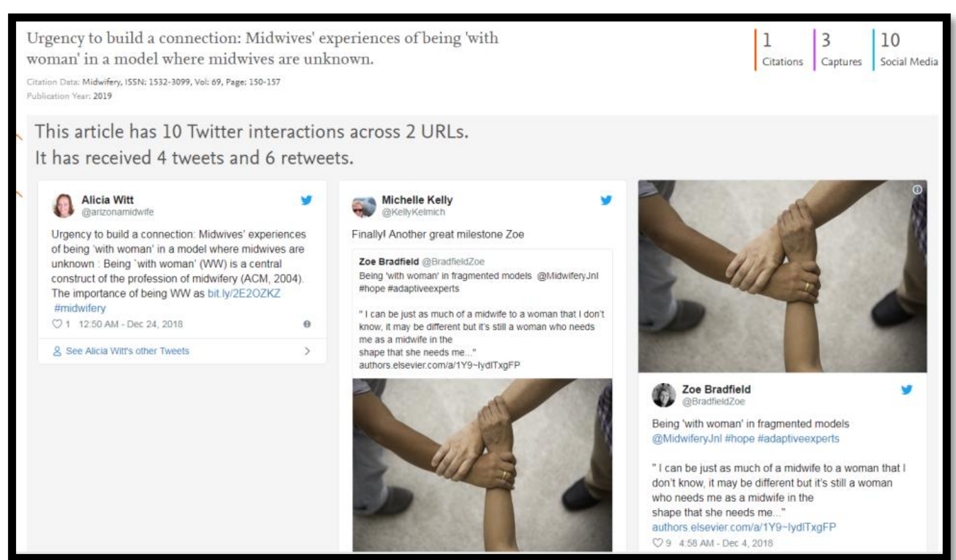
## Appendix J

Copyright clearance for: Urgency to build a connection: Midwives' experiences of being 'with woman' in a model where midwives are unknown

## Appendix K

Research Engagement Evidence: Urgency to build a connection: Midwives' experiences of being 'with woman' in a model where midwives are unknown

Mendeley metrics showing number of downloads (332) and Social Media interactions since publication




PlumX Metrics showing some examples of Social Media interactions since publication

## Appendix L

Copyright clearance confirmation for: Midwives 'with woman' in the private obstetric model: Where divergent philosophies meet

Copyright Clearance Center RightsLink®

Home Create Account Help

Title: Midwives 'with woman' in the private obstetric model: Where divergent philosophies meet
Author: Zoe Bradfield,Michelle Kelly,Yvonne Hauck,Ravani Duggan
Publication: Women and Birth
Publisher: Elsevier
Date: Available online 6 August 2018

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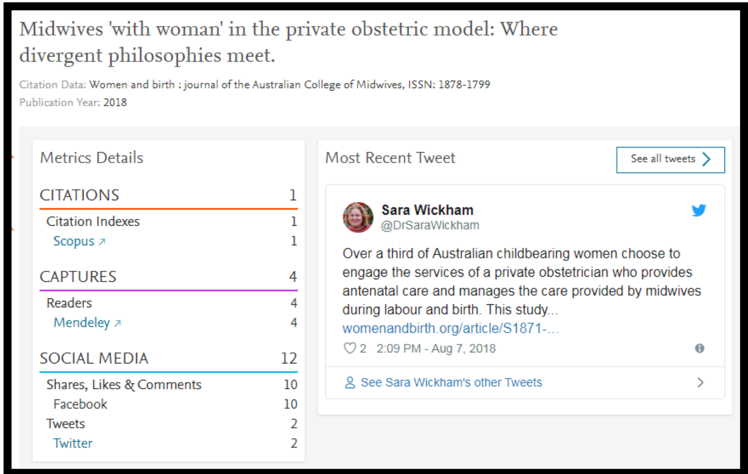
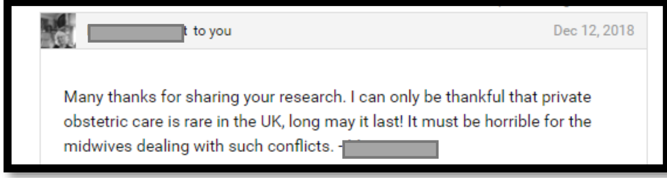
## Appendix M

Research Engagement Evidence: Midwives 'with woman' in the private obstetric model: Where divergent philosophies meet

Mendeley statistics showing 188 downloads of this article since publication in August 2018




PlumXMetrics image showing social media engagement with this article since publication




One example of the multiple requests received through Research Gate for article access

## Appendix N

## Summary of Research Findings Table

| Finding<br>(what) | Study Objective(s)<br>Chapter | Findings<br>(N)<br>(R)<br>(PC) | Implications<br>(so what) | Recommendations<br>(now what) |
|---|---|---|---|---|
| **CLINICAL PRACTICE** | | | | |
| Being WW is not dependent on place of birth or model of care although different factors from each model will impact midwives' experiences of being WW | Obj 1<br>Ch 4 | N | First ever published evidence that the construct of being WW is possible in all maternity models regardless of the option for continuity or not. The way that the phenomenon is experienced though, is different in each model | Midwifery students, graduates and professionals should be encouraged to consider the intersection of their being WW in the context of the various models worked in |
| Building a connection with the woman is an essential feature of being WW | Obj 1, 2<br>Ch 4,5,6,7 | PC | Confirmation in this study that relationship is an essential construct and practice attribute of being WW | Midwifery students, graduates and professionals should prioritise strategies for building connection and relationship in order to be WW |
| Being WW in the context of continuity models enhances midwives' perceptions of providing safer care | Obj 2<br>Ch 5 | N | Being WW in the context of continuity models may increase perceptions of or practices that enhance clinical safety | Further research is warranted to explore midwives' perceptions of the provision of 'safe' clinical care in other models |

| | | | | |
|---|---|---|---|---|
| Being WW is practiced across the continuum of care and features in antenatal, intrapartum and postpartum care | Obj 2<br><br>Ch 5 | N<br>PC | Although widely reported in the literature as a feature of intrapartum care, some expert commentators reference being WW occurs across the continuum too. | Further research is warranted to confirm our findings and to explore the evidence of being 'with woman' in the antenatal and postnatal settings |
| Although reported as the 'most ideal' model to enhance the midwifery practices of being WW – there are challenges experienced by midwives working in continuity models | Obj 2<br><br>Ch 5 | N | Understanding the challenges to being WW within the COC models will help to devise strategies to mitigate these impacts | Further research is recommended on factors that encourage midwives to be prepared, self-aware and consider ways to mitigate the impact of challenges to being WW |
| Providing care to the woman that is inclusive of her support people is an important feature of being WW | Obj 1,2<br><br>Ch 4,5,6,7 | N<br>PC | First ever published evidence that confirms midwives' perceptions and practices of being WW means providing care that is inclusive of the woman's support people – supported by professional commentary | Midwifery students, graduates and professionals should consider ways of providing care that respects the other relationships important to the woman and provides care in an inclusive manner |
| Midwives described a raft of attributes associated with being 'woman – centred' which, for the first time, has been evidenced to construct part of being WW | Obj 1<br><br>Ch 4 | N | First ever published evidence of the conceptualisation of how woman-centred (WC) care intersects with the phenomenon of being WW. Midwives emphasised that providing care that was WC (with a long list of attributes of manifestations of being WC) is a PART of being WW and is the practical outworking of the phenomenon. | Having descriptors of the characteristics and practice attributes of being WW –collectively described as being WC, is new knowledge and is useful conceptualise how these two important constructs articulate in the professional identity, relationships and work of midwifery. New knowledge obtained here may be used to appraise current and future practice standards and supporting documents from midwifery professional bodies around the world. |

| | | | | |
|---|---|---|---|---|
| Forming rapid connections facilitates partnership with the woman and is important to being WW in the UM model | Obj 2<br><br>Ch 6 | N | Skills that enhance rapid connection with the woman are important for midwives, particularly in fragmented models | Midwives should be supported to maintain or develop the necessary skills to establish a rapid connection in order to be with woman and provide care that is centred around her agenda |
| Establishing mutually respectful and collaborative relationships between the woman, midwife and the woman's chosen private obstetrician are important to facilitate midwives being WW | Obj 2<br><br>Ch 7 | N | First ever published evidence of the interconnection between the relationship triad in this setting and being WW | Midwifery and obstetric students, graduates and professionals would be encouraged to consider their role in, and ways in which mutually respectful collaborative relationships could be fostered in order to provide care that is focussed on the best outcomes for women. |
| Midwives feel challenged in being WW by the frequent medical interventions experienced in UMKO model | Obj 2<br><br>Ch 7 | N | Presenting the first ever findings of midwives' experiences of being WW in the context of the private obstetric model gives insight into how this important phenomenon intersects with this model of care | Factors that inhibit midwives to be WW highlighted in this research should be considered by midwifery managers and leaders in an effort to facilitate midwives to work in ways that are consistent with their professional philosophy |
| Midwives reported that a reduction in scope of practice experienced in the private obstetric model impacted being WW | Obj 2<br><br>Ch 7 | N | This first ever published account of how midwives experience limitations in their scope of practice (comparative to other models) enhances understanding about the impacts of this model on the phenomenon of being WW encompassing professional identity and practices | Service and professional leaders should consider ways in which the impacts of this model on midwives' scope of practice could be mitigated or reduced in order to preserve the unique and identifying philosophy and practices of midwifery within this context. Further research is recommended to explore this. |

| EDUCATION | | | | |
|---|---|---|---|---|
| Unique evidence presented in this research reveals the constructs of being WW and how it exhibits in the context of a range of WA models | Obj 1<br><br>Ch 4 | N | For the first time, we have a base of evidence to refer to when teaching midwifery students the features and role of being WW within the profession of midwifery | Midwifery curricula should consider innovative ways to transfer an applied understanding of being WW which is so central to the profession. Further research is warranted on student midwives' perceptions and experiences of being WW; and on the ways being WW is best taught. |
| Midwives expressed difficulty in describing the phenomenon of being WW | Obj 1<br><br>Ch 4 | N | Important findings in this research give language, essence and 'construct' to the phenomenon which makes communication of the same easier to midwifery students in order to develop graduates who can articulate the value, importance and role of professional philosophy in supporting midwifery practices | Midwifery educators in all settings should consider ways to enhance the literacy and description of professional philosophy. Drawing attention to the interconnectedness of philosophy and midwifery practice that support each other. |
| Being WW in the context of continuity models enhances midwives' reflexivity – professional development | Obj 2<br><br>Ch 5 | N | The relationship developed in the WW process provides a space that increases reflexivity and drives the desire for professional development in midwives | In light of increasing availability of continuity models, further research should be undertaken to explore factors that motivate midwives to undertake reflective practice and further professional development |
| Midwives demonstrated adaptability in order to be 'with woman' in an individualised way | Obj 2<br><br>Ch 6 | N | Understanding that adaptability is required in order to be 'with woman' is useful to include in the skills complements of midwifery students, graduates and professionals | Inclusion of teaching and learning of adaptability skills such as scenario based approaches in midwifery curricula and in graduate program training should be considered. Experienced midwives who identify struggle with being adaptive should be supported to increase these skills to enhance being WW |

| PROFESSIONAL LEADERSHIP AND POLICY | | | | |
|---|---|---|---|---|
| Being WW identifies midwifery practice | Obj 1<br><br>Ch 4 | N | Presented for the first time here, descriptions of midwives' perceptions of what being WW means – how it manifests in clinical contexts and is conceptualised by midwives. Understanding how midwives perceive as well as practice the phenomenon is valuable as it offers a glimpse of what is 'ideal' or desired in being WW and then how working in various models intersects with this constructs / conceptualisation of being WW. | The new evidence provided in this research should be considered for how it can support the declarations in the professional philosophy statements of midwifery professional bodies worldwide |
| Continuity models facilitate WW practices and enhance culturally sensitive care | Obj 2<br><br>Ch 5 | N | By providing access to continuity models which facilitate midwives to be WW, services may offer care that is more culturally sensitive | Service providers should consider ways in which they can develop additional and sustain existing continuity models |
| Being WW in the context of continuity models is rewarding and sustaining for midwives | Obj 2<br><br>Ch 5 | R | These findings along with another recent study in Qld show emerging themes of the role of the model of maternity care (specifically COC) in enhancing midwives' wellbeing and choice to stay in the profession. | Traditional recruitment and retention strategies have focussed on remuneration and industrial relations conditions. Further research is warranted into the role of maternity models in attracting and retaining midwifery workforce |
| Increased medical interventions, workloads and fragmented care characteristics of the UM model impact the practice of being WW | Obj 2<br><br>Ch 6 | N | Awareness of the factors that challenge midwives being WW enhances mitigation of the impacts | Service leaders should consider the systems-based impacts on midwives being WW and explore ways to reduce and manage these |

| | | | | |
|---|---|---|---|---|
| In the private obstetric model, midwives who sought to facilitate WW practices such as informed decision making, where the result was the woman choosing a plan of care not preferred by the contracted obstetrician, experienced exclusion from clinical care and verbal abuse | Obj 2<br><br>Ch 7 | N | New evidence presented here reveals the extent of the impact of the private obstetric model on midwives' being WW but also their inter-professional relationships. | Further research is warranted in similar models around Australia to determine if this phenomenon exists beyond the WA context. Midwifery and obstetric managers have an imperative to encourage reporting of unprofessional behaviour and providing supportive workplaces |
| WW practices such as advocacy and education were at times amended by midwives working in the private obstetric model to suit institutional requirements and individual obstetrician preferences | Obj 2<br><br>Ch 7 | N | This new evidence reveals the pressures experienced by midwives in this model to conform to system and obstetrician preferences in ways that could compromise professional practice standards | Midwives should be supported to be WW and demonstrate this through the woman-centred (and professional standards) practices of advocacy and facilitation of informed decision-making based in evidence without fear of reprisal |
| To reduce burn-out attributed to providing care that transgressed professional WW philosophy – midwives in the private obstetric model took advantage of the family-friendly rostering and rotation to areas other than birth suite as required | Obj 2<br><br>Ch 7 | N | This first ever glimpse at the self-preservation strategies employed by midwives in this model to enhance career longevity, reveals some of the factors that enhanced resilience | Further research is warranted on factors that impact workforce sustainability in this model with consideration to factors that impact sustainability in other settings such as woman-centred continuity models |
| **RESEARCH** | | | | |
| Further research is recommended to explore the features of being WW across the continuum including antenatal and postnatal care | Obj 2<br><br>Ch 5 | | Would provide an understanding of the features of being WW across the childbearing continuum | |

| | | | | |
|---|---|---|---|---|
| An exploration of how being WW is experienced from the perspective of the partner or significant others could be considered | Obj 2<br><br>Ch 5,6,7 | | This offers respect for the role of the support person and seeks to understand their perspectives which further enhances midwives' ability to be WW inclusive of partners or support people | |
| Further research should be conducted on women's experiences of care in different models in a way that either seeks to describe or compare the experiences | Obj 2<br><br>Ch 5 | | Would provide unique insight into individuals' experiences of various models of care | |
| An area for future research identified in this study is to explore midwives' experiences of working in different models | Obj 2<br><br>Ch 5 | | This would add to the current knowledge that considers experiences in one context by offering descriptions of different contexts from the same midwife | |
| Further research is warranted on the impacts of and women's reasons for declining professional relationship or partnership | Obj 2<br><br>Ch 5 | | A complex and nuanced phenomenon, having better understanding of this would assist midwives to develop skills sensitive to those who decline partnership | |
| Further study is indicated to explore the best way to teach midwifery students the phenomenon of being WW | Obj 1<br><br>Ch 4 | | Being WW is so fundamental to the profession of midwifery. With enhanced understanding of the phenomenon provided in this study – discovering how this important construct is best taught would be useful | |

| | | | | |
|---|---|---|---|---|
| From this study, further research is warranted on women's perceptions and experiences of their relationship with a chosen, contracted private obstetrician | Obj 2<br><br>Ch 7 | | There is a current gap in research in this area | |
| From this study, further research should be conducted on private obstetricians' perceptions and experiences of their continuity relationship with women contracted to them | Obj 2<br><br>Ch 7 | | There is a current gap in research in this area | |

**Abbreviations**

COC – Continuity of Care

N – New

R – Research

PC – Professional Commentary

WA – Western Australia

WW – With Woman

**END OF THESIS**